

## MEDICAL BENEFITS

The following Medical Benefits are payable as stated in the Schedule of Medical Benefits subject to any benefit limits specifically stated in the Schedule and all terms and conditions of this Plan.

1. Charges made by a Hospital for:
  - A. Daily Room and Board in a Semi-Private Room (or private room if no Semi-Private room is available or when confinement in a private room is Medically Necessary) and general nursing services, or confinement in an Intensive Care Unit, not to exceed the applicable limits shown in the Schedule of Medical Benefits.
  - B. Medically Necessary Hospital Miscellaneous Expenses other than Room and Board furnished by the Hospital, including Inpatient miscellaneous service and supplies, Outpatient Hospital treatments for chronic conditions and emergency room use for an Emergency only, Physical Therapy treatments, hemodialysis, and x-ray.
  - C. Nursery neonatal units, general nursing services, including Hospital Miscellaneous Expenses for services and supplies, Physical Therapy, hemodialysis and x-ray, care or treatment of Injury or Illness, congenital defects, birth abnormalities or premature delivery incurred by a Newborn Dependent.
  - D. Therapy which has been prescribed by the speech pathologist or Physician and includes a written treatment plan with estimated length of time for therapy.

**Treatment rendered for stuttering or for behavioral or learning disorders is excluded.**

2. Charges made by an Ambulatory Surgical Center when treatment has been rendered.

"Ambulatory Surgical Center" (also called same-day surgery center or Outpatient surgery center) means a licensed establishment with an organized staff of Physicians and permanent facilities, either freestanding or as a part of a Hospital, equipped and operated primarily for the purpose of performing surgical procedures and which a patient is admitted to and discharged from within a twenty-four (24) hour period. Such facilities must provide continuous Physician and registered nursing services whenever a patient is in the facility. An Ambulatory Surgical Center must meet any requirements for certification or licensing for surgical facilities in the state in which the facility is located.

"Ambulatory Surgical Center" does not include an office or clinic maintained by a Dentist or Physician for the practice of dentistry or medicine, a Hospital emergency room or trauma center.

3. Charges made by an Urgent Care Facility when treatment has been rendered.

"Urgent Care Facility" means a free-standing facility which is engaged primarily diagnosing and treating Illness or Injury for unscheduled, ambulatory Covered Persons seeking immediate medical attention. A clinic located in or in conjunction with or in any way made a part of a regular Hospital will be excluded from the terms of this definition.

4. Charges for services and supplies furnished by a Birthing Center.

5. Charges made by a Skilled Nursing Facility for the following services and supplies furnished by the facility during the first sixty (60) days of convalescent confinement in any one Convalescent Period. Only charges in connection with convalescence from the illness or injury for which the Covered Person was Hospital-confined will be eligible for benefits. These expenses include:
  - A. Room and Board, including any charges made by the facility as a condition of occupancy, or on a regular daily or weekly basis such as general nursing services. If private room accommodations are used, the daily Room and Board charge allowed will not exceed the facility's average Semi-Private charges or an average Semi-Private rate made by a representative cross section of similar institutions in the area.
  - B. Medical services customarily provided by the Skilled Nursing Facility, with the exception of private duty or special nursing services and Physicians' fees.
  - C. Drugs, biologicals, solutions, dressings and casts, furnished for use during the Convalescent Period, but no other supplies.

"Convalescent Period" means a period of time commencing with the date of confinement by a Covered Person in a Skilled Nursing Facility.

A Convalescent Period will terminate when the Covered Person has been free of confinement in any and all institutions providing Hospital or nursing care for a period of ninety (90) consecutive days. A new Convalescent Period will not commence until a previous Convalescent Period has terminated.

6. Charges made by a Hospice within any one Hospice Benefit Period for:
  - A. Room and Board, including any charges made by the facility as a condition of occupancy, or on a regular daily or weekly basis such as general nursing services. If private room accommodations are used, the daily Room and Board charge allowed will not exceed the facility's average Semi-Private charges or an average Semi-Private rate made by a representative cross section of similar institutions in the area.
  - B. Nursing care by a Registered Nurse (R.N.), a Licensed Practical Nurse (L.P.N.), a public health nurse who is under the direct supervision of a Registered Nurse.
  - C. Physical Therapy and Speech Therapy, when rendered by a licensed therapist.
  - D. Medical supplies, including drugs and biologicals and the use of medical appliances.
  - E. Physician's services.
  - F. Services, supplies, and treatments deemed Medically Necessary and ordered by a licensed Physician.
7. The services of a legally qualified Physician or Licensed Health Care Provider for medical care and/or treatments, including office, home visits, Hospital Inpatient care, Hospital Outpatient visits/exams, clinic care, and surgical opinion consultations.
 

Charges are eligible for drugs intended for use in a Physicians' office or settings other than home use that are billed during the course of an evaluation or management encounter.
8. Charges for Pregnancy, including charges for prenatal care, childbirth, miscarriage, and any medical complications arising out of or resulting from Pregnancy.

9. Charges for Surgical Procedures.

When two or more Surgical Procedures occur during the same operative session, charges will be considered as follows:

- A. When multiple or bilateral Surgical Procedures are performed that increase the time and amount of patient care, 100% of the Eligible Expense will be considered for the Major Procedure; and 50% of the Eligible Expense will be considered for each of the lesser procedures, except for contracted or negotiated services. Contracted or negotiated services will be reimbursed at the contracted or negotiated rate.
- B. When an incidental procedure is performed through the same incision, only the Eligible Expense for the Major Procedure will be considered. Examples of incidental procedures are: excision of a scar, appendectomy at the time of other abdominal surgery, lysis of adhesions, etc.

When an assisting Physician is required to render technical assistance during a Surgical Procedure, the charges for such services will be limited to 25% of the primary surgeon's Eligible Expense for the Surgical Procedure. When an assisting non-physician is required to render technical assistance during an operation, charges for such services will be limited to 10% of the surgeon's Eligible Expense for the Surgical Procedure.

10. Charges for Registered Nurses (R.N.'s) or Licensed Practical Nurses (L.P.N.'s) for private duty nursing.

11. Charges for midwife services by a Certified Nurse Midwife (CNM) who is a registered nurse and enrolled in either the certification maintenance program or the continuing competency assessment program through the American College of Nurse Midwives (ACNM).

"Certified Nurse Midwife" means an individual who has received advanced nursing training and is authorized to use the designation of "CNM" and who is licensed by the state or regulatory agency in the state in which the individual performs such nursing services.

12. Charges for home and Outpatient infusion services ordered by a Physician and provided by a Home and Outpatient Infusion Therapy Organization licensed and approved within the state in which the services are provided. A "Home and Outpatient Infusion Therapy Organization" is a health care facility that provides home and Outpatient infusion therapy services and skilled nursing services. Home and Outpatient infusion therapy services include the preparation, administration, or furnishing of parenteral medications, or parenteral or enteral nutritional services to a Covered Person by a Home and Outpatient Infusion Therapy Organization. Services also include education for the Covered Person, the Covered Person's care giver, or a family member. Home and Outpatient infusion therapy services include pharmacy, supplies, equipment and skilled nursing services when billed by a Home and Outpatient Infusion Therapy Organization.

**Skilled nursing services billed by a home health agency are covered under the Home Health Care Benefit.**

13. Charges for Physical Therapy or Occupational Therapy whose primary purpose is to provide medical care for an illness or injury, on an Inpatient or Outpatient basis. Physical Therapy or Occupational Therapy must be ordered by a Physician and rendered by a licensed physical or occupational therapist.

14. Charges made by a licensed speech therapist for Speech Therapy, also called speech pathology, and audio diagnostic testing services for diagnosis and treatment of speech and language disorders. The Plan will provide benefits for Speech Therapy when all of the following criteria are met:
  - A. There is a documented condition or delay in development that can be expected to improve with therapy within a reasonable time.
  - B. Improvement would **not** normally be expected to occur without intervention.
  - C. Treatment is **not** rendered for stuttering.
  - D. Treatment is **not** rendered for behavioral or learning disorders.
  - E. Treatment is rendered for a condition that is the direct result of a diagnosed neurological, muscular, or structural abnormality affecting the organs of speech.
  - F. Therapy has been prescribed by the speech language pathologist or Physician and includes a written treatment plan with estimated length of time for therapy, along with a statement certifying all above conditions are met.
15. Charges for Ambulance Service to the nearest facility where Emergency care or treatment can be rendered; **The Plan will not pay for Ambulance Service from the facility to the patient's home.**
16. Charges for drugs requiring the written prescription of a Physician or a Licensed Health Care Provider and Medically Necessary for the treatment of an Illness or Injury. Coverage also includes prescription contraceptive drugs not available through the Pharmacy Benefit regardless of Medical Necessity.
 

**Conditions of coverage for outpatient prescription drugs and supplies available through the Pharmacy Benefit are as stated in the Schedule of Benefits and Pharmacy Benefit sections of the Plan.**
17. Charges for x-rays, CAT scans, MRIs, microscopic tests, and laboratory tests.
18. Charges for radiation therapy or treatment and chemotherapy.
19. Charges for blood transfusions, blood processing costs, blood transport charges, blood handling charges, administration charges, and the cost of blood, plasma and blood derivatives. Any credit allowable for replacement of blood plasma by donor or blood insurance will be deducted from the total Eligible Expenses.
20. Charges for oxygen and other gases and their administration.
21. Charges for electrocardiograms, electroencephalograms, pneumoencephalograms, basal metabolism tests, or similar well-established diagnostic tests generally accepted by Physicians throughout the United States.
22. Charges for the cost and administration of an anesthetic.

23. Charges by a Physician or Licensed Health Care Provider for dressings, sutures, casts, splints, trusses, crutches, braces, adhesive tape, bandages, antiseptics or other Medically Necessary medical supplies, except for dental braces or corrective shoes, which are specifically excluded.

Diabetic supplies, including syringes, needles, insulin injectable devices, swabs, blood test strips, blood glucose calibration solutions, urine tests, lancets, and lancet devices. Insulin, needles, syringes and test strips are eligible under the Pharmacy Benefit of this Plan.

24. Charges for pump supplies, blood monitors and kits.

Blood monitors and kits are also available for coverage under the Pharmacy Benefit as stated in the Pharmacy Benefit section of the Plan.

25. Charges for adhesive tape, bandages, antiseptics or other over-the-counter first aid supplies except only upon prior approval of the Plan. **Approval will be based on guidelines of cost effectiveness and Medically Necessary treatment of an illness or injury as determined by the Plan Administrator.**

26. Charges for the Durable Medical Equipment, Orthopedic Appliances, or Prosthetic Appliances as follows:

- A. Rental of, up to the purchase price of, a wheelchair, Hospital bed, respirator or other Durable Medical Equipment required for therapeutic use, or the purchase of this equipment if economically justified, whichever is less. For Durable Medical Equipment for which purchase is not medically feasible, rental charges will be paid without limitation based upon purchase price.
- B. Purchase of Orthopedic Appliances or Prosthetic Appliances including, but not limited to, artificial limbs, eyes, larynx.
- C. Replacement or repair of Durable Medical Equipment, Orthopedic Appliances, Prosthetic Appliances.

Pre-treatment Review of charges for Durable Medical Equipment, Orthopedic Appliances or Prosthetic Appliances that may exceed \$5,000 is strongly recommended. If Pre-treatment review is not obtained, charges may be denied if the service, treatment or supply is not found to be Medically Necessary or found to be otherwise excluded by the Plan when the claim is submitted.

27. Charges for voluntary sterilization for Participants and Dependent spouses only.

28. Charges in connection with non-Experimental or non-Investigational organ or tissue transplant procedures, subject to the following conditions:

- A. A second opinion is recommended prior to undergoing any transplant procedure. This second opinion should concur with the attending Physician's findings regarding the Medical Necessity of such procedure. The Physician rendering this second opinion must be qualified to render such a service either through experience, specialist training or education, or such similar criteria, and must not be affiliated in any way with the Physician who will be performing the actual surgery.
- B. If the donor is covered under this Plan, expenses incurred by the donor will be considered for benefits to the extent that such expenses are not payable by the recipient's plan.

- C. If the recipient is covered under this Plan, expenses Incurred by the recipient will be considered for benefits. Expenses Incurred by the donor, who is not ordinarily covered under this Plan according to eligibility requirements, will be considered Eligible Expenses to the extent that such expenses are not payable by the donor's plan. In no event will benefits be payable in excess of the applicable benefit limits still available to the recipient.
  - D. If both the donor and the recipient are covered under this Plan, Expenses Incurred by each person will be treated separately for each person.
  - E. The Eligible Expense of securing an organ from a cadaver or tissue bank, including the surgeon's charge for removal of the organ and a Hospital's charge for storage or transportation of the organ, will be considered for payment.
29. Reasonable charges for producing medical records only if incurred for the purpose of utilization review, audits or investigating a claim for benefits if requested and approved by the Plan. Charges that exceed limits for such charges imposed by applicable law will not be deemed to be reasonable.
30. Charges made by a Home Health Care Agency for care in accordance with a Home Health Care Plan. Coverage under this benefit includes the following services:
- A. Part-time or intermittent nursing care by a Registered Nurse (R.N.) or by a Licensed Practical Nurse (L.P.N.), a vocational nurse, or public health nurse who is under the direct supervision of a Registered Nurse;
  - B. Home health aides;
  - C. Medical supplies, drugs and medicines prescribed by a Physician, and laboratory services provided by or on behalf of a Hospital.

"Home Health Care Agency" means an organization that provides skilled nursing services and therapeutic services (home health aide services, physical therapy, occupational therapy, speech therapy, medical social services) on a visiting basis, in a place of residence used as the Covered Person's home. The organization must be Medicare certified and licensed within the state in which home health care services are provided.

"Home Health Care Plan" means a program for continued care and treatment administered by a Medicare certified and licensed Home Health Care Agency, for the Covered Person who may otherwise have been confined as an Inpatient in a Hospital or Skilled Nursing Facility or following termination of a Hospital confinement as an Inpatient and is the result of the same related condition for which the Covered Person was hospitalized and is approved in writing by the Covered Person's attending Physician.

**Home Health Care specifically excludes the following:**

- A. Services and supplies not included in the approved Home Health Care Plan.
- B. Services of a person who ordinarily resides in the home of the Covered Person, or who is a Close Relative of the Covered Person who does not regularly charge the Covered Person for services.
- C. Services of any social worker.
- D. Transportation services.
- E. Housekeeping services.

F. Custodial Care.

31. Charges for Contraceptive Management, regardless of Medical Necessity. "Contraceptive Management" means Physician fees related to a prescription contraceptive device, obtaining a prescription for contraceptives, purchasing, fitting, injecting, implantation or placement of any contraceptive device.
32. Charges for the following Mental Illness Services:
  - A. Physician or Licensed Health Care Provider charges for diagnosis and Medically Necessary Psychiatric Care and treatment.
  - B. Well-established medically accepted diagnostic testing generally accepted by Physicians in the United States.
  - C. In-patient and partial hospitalization, for Medically Necessary treatment, for the same services as are covered for hospitalization for physical Illness or Injury by this Plan.
  - D. Medically Necessary treatment at a Psychiatric Facility.
33. Charges for the following Alcoholism and/or Chemical Dependency Services:
  - A. Physician or Licensed Health Care Provider charges for diagnosis and Medically Necessary treatment including, but not limited to, group therapy.
  - B. Well-established medically accepted diagnostic testing generally accepted by Physicians in the United States.
  - C. In-patient and partial hospitalization, for Medically Necessary treatment, for the same services as are covered for hospitalization for physical Illness or Injury by this Plan.
  - D. Medically Necessary treatment, including aftercare, at an Alcoholism and/or Chemical Dependency Treatment Facility.
34. Charges for "Routine Patient Costs" for a Phase I "Approved Clinical Trial".
 

"Routine Patient Costs" include but are limited to Medically Necessary services which a Covered Person with the identical diagnosis and current condition would receive even in the absence of participating in an Approved Clinical Trial.

"Routine Patient Costs" do not include any investigational item, device, or service that is part of the Approved Clinical Trial; an item or service provided solely to satisfy data collection and analysis needs for the trial if the item or service is not used in the direct clinical management of the patient; a service that is clearly inconsistent with widely accepted and established standards of care for the individual's diagnosis; or an item or service customarily provided and paid for by the sponsor of an Approved Clinical Trial.

"Approved Clinical Trial" means a Phase I clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer and is not designed exclusively to test toxicity or disease pathophysiology. The Trial must be:

  - A. Conducted under an investigational new drug application reviewed by the United States Food and Drug Administration;
  - B. Exempt from obtaining an investigational new drug application; or

- C. Approved or funded by:
- 1) The National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, Centers for Medicare and Medicaid Services, or a cooperative group or center of any of the entities described above;
  - 2) A cooperative group or center of the United States Department of Defense or the United States Department of Veterans Affairs;
  - 3) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support groups; or
  - 4) The United States Departments of Veterans Affairs, Defense, or Energy if the study or investigation has been reviewed and approved through a system of peer review determined by the United States Secretary of Health and Human Services to:
    - a) be comparable to the system of peer review of studies and investigations used by the national institutes of health; and
    - b) provide unbiased scientific review by individuals who have no interest in the outcome of the review.

NEWBORN INPATIENT NURSERY/PHYSICIAN CARE

Charges are payable as specifically stated in the Schedule of Medical Benefits. Newborn Inpatient Nursery/Physician Care including the following services:

1. Nursery Care includes room, board and Hospital Miscellaneous Expenses for a Newborn Dependent child, including circumcision.
2. Physician Care includes charges for services of a Physician for a Newborn Dependent child while Inpatient as a result of the child's birth, including circumcision.

PREVENTIVE CARE (Not applicable to Optional Retiree Plan)

Charges are payable as specifically stated and limited in the Schedule of Medical Benefits for "Preventive Care".

"Preventive Care" means routine treatment or examination provided when there is no objective indication or outward manifestation of impairment of normal health or normal bodily function, which is not provided as a result of any Injury or Illness.

Coverage under this benefit includes the following routine services, subject to the following limitations:

1. Routine Outpatient Well-Child Care for Dependent children through age seven (7) years for the following routine services:
  - A. Well-child examinations by a Physician, which will include a medical history, physical examination, developmental assessment, anticipatory guidance and laboratory tests as directed by a Physician.
  - B. Routine immunizations according to the schedule of immunizations which is recommended by the Immunization Practices Advisory Committee of the United States Department of Health and Human Services.
2. Routine well adult care eighteen (18) years or older includes care by a Physician for routine services: pap smear, mammogram, prostate, gynecological, routine physical examination, x-rays and laboratory blood tests.

3. Influenza virus vaccine and its administration.

**Expenses payable under this Preventive Care benefit will not be subject to the Medical Necessity provisions of this Plan. Charges for Preventive Care that involve excessive, unnecessary or duplicate tests are specifically excluded.**

**Charges for treatment of an active illness or injury are subject to the Plan provisions, limitations and exclusions and are not eligible in any manner under Preventive Care.**

PREVENTIVE CARE - OPTIONAL RETIREE PLAN

Charges are payable as specifically stated and limited in the Schedule of Medical Benefits for "Preventive Care".

"Preventive Care" means routine treatment or examination provided when there is no objective indication or outward manifestation of impairment of normal health or normal bodily function, which is not provided as a result of any injury or illness.

Coverage under this benefit includes the following routine services, subject to the following limitations:

1. Routine Outpatient Well-Child Care for Dependent children through age seven (7) years for the following routine services:
  - A. Well-child examinations by a Physician, which will include a medical history, physical examination, developmental assessment, anticipatory guidance and laboratory tests as directed by a Physician, but not to exceed a total of ten (10) visits through twenty-four (24) months of age and one visit per Benefit Period between two (2) and seven (7) years of age.
  - B. Routine immunizations according to the schedule of immunizations which is recommended by the Immunization Practices Advisory Committee of the United States Department of Health and Human Services.
2. Routine well adult care eighteen (18) years or older includes care by a Physician for routine services: pap smear, mammogram, prostate, gynecological, routine physical examination, x-rays and laboratory blood tests.

Frequency limits for mammogram are as follows:

- A. A single baseline mammogram for women ages 35 through 39.
  - B. One routine mammogram every two years for women ages 40 through 49, or more frequently as recommended by a Physician.
  - C. One routine mammogram every year for women age 50 or older.
3. Influenza virus vaccine and its administration, limited to one per benefit period.

**Expenses payable under this Preventive Care benefit will not be subject to the Medical Necessity provisions of this Plan.**

**Charges for treatment of an active illness or injury are subject to the Deductible and Benefit Percentage and other Plan provisions, limitations and exclusions and are not eligible in any manner under Preventive Care.**

GENETIC TESTING FOR BRCA1 AND BRCA2 MUTATION

Testing must be specifically ordered by the Covered Person's treating Physician.

Genetic testing for BRCA1 and BRCA2 gene mutation is covered subject to the limitations stated in the Schedule of Benefits and subject further to the following:

1. The Covered Person has been diagnosed with breast cancer.
2. The Covered Person has been diagnosed with ovarian cancer.
3. The Covered Person has a blood relative within the second degree (parent, aunt, uncle, brother, sister or first cousin) who has been diagnosed with breast cancer.

Coverage of this testing shall not be construed in any manner to be authorization for either prophylactic mastectomy or oophorectomy

RECONSTRUCTIVE BREAST SURGERY/NON-SURGICAL AFTER CARE BENEFIT

Coverage includes charges for reconstructive breast surgery subsequent to any Medically Necessary mastectomy, limited to charges for the following:

1. Reconstruction of the breast(s) upon which the mastectomy was performed, including implants;
2. Surgical procedures and reconstruction of the non-affected breast to produce a symmetrical appearance, including implants;
3. Non-surgical treatment of lymphedemas and other physical complications of mastectomy, including non-surgical prostheses and implants for producing symmetry.

Specifically excluded from this benefit are expenses for the following:

1. Solely Cosmetic procedures unrelated to producing a symmetrical appearance;
2. Breast augmentation procedures unrelated to producing a symmetrical appearance;
3. Implants for the non-affected breast unrelated to producing a symmetrical appearance;
4. Non-surgical prostheses or any other procedure unrelated to producing a symmetrical appearance.

ROUX-EN-Y DIVIDED GASTRIC BYPASS SURGERY BENEFIT

1. Coverage is provided for Participants (Covered Employees) only. **No coverage is provided for Dependents.**
2. Coverage is limited to one procedure per lifetime.
3. No coverage is provided for any Participant who has had any previous surgical procedure for weight control including, but not limited to, gastric bypass surgery, stomach stapling, stomach banding or gastroplasty.

"Morbid Obesity/Clinically Severe Obesity" means maintaining a medically documented Body Mass Index (BMI) of 35 or more for a period of at least the twelve (12) consecutive months immediately before the proposed surgery, combined with at least one of the following current conditions which must be documented by a Physician as life-threatening:

1. Severe sleep apnea;
2. Pickwickian syndrome;
3. Congestive heart failure;
4. Cardiomyopathy;
5. Insulin dependent or oral medication dependent diabetes;
6. Severe Musculoskeletal dysfunction;
7. Gastric Esophageal Reflux Disorder;
8. Pulmonary edema; or
9. Hypertension.

Body Mass Index (BMI) is calculated by dividing a person's weight (in kilograms) by his/her height squared (in meters).

Charges for Roux-En-Y Divided Gastric Bypass surgery, including directly related presurgical assessment and or counseling, directly related post-surgical follow-up care and complications as a result of surgery are covered up to the limits set out in the Schedule of Benefits, subject to the following conditions, which must be verified through independent medical review by the Plan:

1. A clinical history of at least two (2) years of unsuccessful diet and other weight management programs.
2. The Participant must undergo and successfully complete any pre-surgical evaluation program provided by the facility providing the surgery. The program must include post-operative follow-up.
3. Must receive a positive assessment of surgery risk-benefit from all evaluating staff members of the pre-surgery program.
4. Must be at least 18 years of age and less than 70 years of age.

Charges incurred for weight reduction, weight loss, the treatment of obesity and the treatment of Morbid Obesity/Clinically Severe Obesity are excluded for the following:

1. Non surgical treatment for weight gain, weight reduction or weight maintenance including, but not limited to, prescription drugs, vitamins, food supplements, counseling, diet and educational programs.
2. Surgical procedures except for Roux-En-Y Divided Bypass Surgery.
3. Any Expenses Incurred for which all of the conditions of the Roux-En-Y Divided Bypass Surgery Benefit of this Plan have not been met.
4. Any redo or revision of a prior bariatric surgical procedure.

5. A second bariatric surgical procedure, whether or not the first procedure was performed while covered under this Plan or not.
6. Treatment of a Dependent.
7. If the Participant has had any prior bariatric surgical procedure during his/her lifetime including, but not limited to, prior gastric bypass, stomach stapling, stomach banding, or gastroplasty.

NEW YORK STATE EXPENSES

Coverage for charges incurred in New York include all charges that are eligible under this Plan. However, the Plan will not pay any surcharge or tax of any nature imposed by the State of New York upon services, treatments or supplies.