



# Benefit Summary

Texas - Insurance Choice Plus  
Premier - 35/7500/100% Plan T93

We know that when people know more about their health and health care, they can make better informed health care decisions. We want to help you understand more about your health care and the resources that are available to you.

- **myuhc.com**<sup>®</sup> – Take advantage of easy, time-saving online tools. You can check your eligibility, benefits, claims, claim payments, search for a doctor and hospital and much, much more.
- **24-hour nurse support** – A nurse is a phone call away and you have other health resources available 24-hours a day, 7 days a week to provide you with information that can help you make informed decisions. Just call the number on the back of your ID card.
- **Customer Care telephone support** – Need more help? Call a customer care professional using the toll-free number on the back of your ID card. Get answers to your benefit questions or receive help looking for a doctor or hospital.

## PLAN HIGHLIGHTS

Types of Coverage	Network Benefits	Non-Network Benefits
<b>Annual Deductible</b>		
Individual Deductible	\$7,500 per year	\$15,000 per year
Family Deductible	\$22,500 per year	\$45,000 per year
<ul style="list-style-type: none"> <li>&gt; Member Copayments do not accumulate towards the Deductible.</li> <li>&gt; All individual Deductible amounts will count toward the family Deductible, but an individual will not have to pay more than the individual Deductible amount.</li> <li>&gt; This benefit plan contains a Per Occurrence Deductible that applies to certain Covered Health Services. This Per Occurrence Deductible must be met prior to and in addition to the Annual Deductible.</li> </ul>		

<b>Out-of-Pocket Maximum</b>		
Individual Out-of-Pocket Maximum	No Out-of-Pocket Maximum	\$15,000 per year
Family Out-of-Pocket Maximum	No Out-of-Pocket Maximum	\$45,000 per year
<ul style="list-style-type: none"> <li>&gt; Member Copayments and Per Occurrence Deductibles do not accumulate towards the Out-of-Pocket Maximum.</li> <li>&gt; All individual Out-of-Pocket Maximum amounts will count toward the family Out-of-Pocket Maximum, but an individual will not have to pay more than the individual Out-of-Pocket Maximum amount.</li> <li>&gt; The Out-of-Pocket Maximum does not include the Annual Deductible.</li> </ul>		

<b>Benefit Plan Coinsurance - The Amount We Pay</b>		
	100% after Deductible has been met.	70% after Deductible has been met.

This Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary conflicts in any way with the Certificate of Coverage (COC), the COC shall prevail. It is recommended that you review your COC for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

**TXWG6T9311**

Item#	Benefit Accumulator	Rev. Date		
275-6250	Calendar Year	1011	BB-022/Sep/Emb/8377	TX DOI Form CCOV.I.11.TX
UnitedHealthcare Insurance Company				

## Prescription Drug Benefits

Prescription drug benefits are shown under separate cover.

## Information on Benefit Limits

- > The Annual Deductible, Out-of-Pocket Maximum and Benefit limits are calculated on a calendar year basis.
- > All Benefits are reimbursed based on Eligible Expenses. For a definition of Eligible Expenses, please refer to your Certificate of Coverage.
- > When Benefit limits apply, the limit refers to any combination of Network and Non-Network Benefits unless specifically stated in the Benefit category.

## MOST COMMONLY USED BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
<b>Physician's Office Services - Sickness and Injury</b>		
Primary Physician Office Visit No deductible is applicable to necessary diagnostic follow-up care relating to the screening test for hearing loss of newborn Dependents, from birth through 24 months.	Network: 100% after you pay a \$35 Copayment per visit.	70% after Deductible has been met.
Specialist Physician Office Visit	Designated Network: 100% after you pay a \$35 Copayment per visit. Network: 100% after you pay a \$70 Copayment per visit.	70% after Deductible has been met.  <i>Prior Authorization is required for Genetic Testing - BRCA.</i>
> In addition to the visit Copayment, the applicable Copayment and any Deductible/Coinsurance applies when these services are done: CT, PET, MRI, MRA, Nuclear Medicine; Pharmaceutical Products, Scopic Procedures; Surgery; Therapeutic Treatments.		
<b>Preventive Care Services</b>		
Covered Health Services include but are not limited to:		
Primary Physician Office Visit	100%, Copayments and Deductibles do not apply.	70% after Deductible has been met.
Specialist Physician Office Visit	100%, Copayments and Deductibles do not apply.	
Lab, X-Ray or other preventive tests	100%, Copayments and Deductibles do not apply.	
<b>Urgent Care Center Services</b>		
	100% after you pay a \$100 Copayment per visit.	70% after Deductible has been met.
> In addition to the visit Copayment, the applicable Copayment and any Deductible/Coinsurance applies when these services are done: CT, PET, MRI, MRA, Nuclear Medicine; Pharmaceutical Products, Scopic Procedures; Surgery; Therapeutic Treatments.		
<b>Emergency Health Services - Outpatient</b>		
	100% after you pay a \$300 Copayment per visit.	100% after you pay a \$300 Copayment per visit.  <i>Notification is required if confined in a non-Network Hospital.</i>

**MOST COMMONLY USED BENEFITS****YOUR BENEFITS**

Types of Coverage	Network Benefits	Non-Network Benefits
Hospital - Inpatient Stay	100% after Deductible has been met.	70% after: Per Occurrence Deductible of \$500 and Annual Deductible have been met.  <i>Prior Authorization is required.</i>

**ADDITIONAL CORE BENEFITS**

Types of Coverage	Network Benefits	Non-Network Benefits
<b>Ambulance Service - Emergency and Non-Emergency</b>		
Ground Ambulance	100% after Deductible has been met.	100% after Network Deductible has been met.
Air Ambulance	100% after Deductible has been met.	100% after Network Deductible has been met.
	<i>Prior Authorization is required for non-Emergency Ambulance.</i>	<i>Prior Authorization is required for non-Emergency Ambulance.</i>
<b>Congenital Heart Disease (CHD) Surgeries</b>		
	100% after Deductible has been met.	70% after: Per Occurrence Deductible of \$500 and Annual Deductible have been met.
		<i>Prior Authorization is required.</i>
<b>Dental Services - Accident Only</b>		
Benefits are limited as follows: \$3,000 maximum per year \$900 maximum per tooth	100% after Deductible has been met.	100% after Network Deductible has been met.
	<i>Prior Authorization is required.</i>	<i>Prior Authorization is required.</i>
<b>Diabetes Services</b>		
Diabetes Self Management and Training Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
Diabetes Self Management Items Benefits for diabetes equipment that meets the definition of Durable Medical Equipment are not subject to the limit stated under Durable Medical Equipment. Benefits for podiatric appliances are limited to two pairs of therapeutic footwear per year for the prevention of complications associated with diabetes.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under Durable Medical Equipment and in the Outpatient Prescription Drug Rider.	
		<i>Prior Authorization is required for diabetes equipment in excess of \$1,000.</i>
<b>Durable Medical Equipment</b>		
Benefits are limited as follows: \$2,500 per year and are limited to a single purchase of a type of Durable Medical Equipment (including repair and replacement) every three years. This limit does not apply to wound vacuums.	100% after Deductible has been met.	70% after Deductible has been met.
		<i>Prior Authorization is required for Durable Medical Equipment in excess of \$1,000.</i>

This benefit category contains services/devices that may be Essential or non-Essential Health Benefits as defined by the Patient Protection and Affordable Care Act depending upon the service or device delivered. A benefit review will take place once the dollar limit is exceeded. If the service/device is determined to be rehabilitative or habilitative in nature, it is an Essential Health Benefit and will be paid. If the benefit/device is determined to be non-essential, the maximum will have been met and the claim will not be paid.

**ADDITIONAL CORE BENEFITS**

**YOUR BENEFITS**

Types of Coverage	Network Benefits	Non-Network Benefits
<b>Hearing Aids</b>		
Benefits are limited as follows: \$2,500 per year and are limited to a single purchase (including repair/ replacement) per hearing impaired ear every three years.	100% after Deductible has been met.	70% after Deductible has been met.
<b>Home Health Care</b>		
Benefits are limited as follows: 60 visits per year	100% after Deductible has been met.	70% after Deductible has been met. <i>Prior Authorization is required.</i>
<b>Hospice Care</b>		
	100% after Deductible has been met.	70% after Deductible has been met. <i>Prior Authorization is required for Inpatient Stay.</i>
<b>Lab, X-Ray and Diagnostics - Outpatient</b>		
For Preventive Lab, X-Ray and Diagnostics, refer to the Preventive Care Services category.		
Lab Testing - Outpatient	100% Deductible does not apply.	70% after Deductible has been met.
X-Ray and Other Diagnostic Testing - Outpatient	100% Deductible does not apply.	70% after Deductible has been met.
<b>Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient</b>		
	100% after Deductible has been met.	70% after Deductible has been met.
<b>Ostomy Supplies</b>		
Benefits are limited as follows: \$2,500 per year	100% after Deductible has been met.	70% after Deductible has been met.
<b>Pharmaceutical Products - Outpatient</b>		
This includes medications administered in an outpatient setting, in the Physician's Office, or in a Covered Person's home.	100% after Deductible has been met.	70% after Deductible has been met.
<b>Physician Fees for Surgical and Medical Services</b>		
	100% after Deductible has been met.	70% after Deductible has been met.
<b>Pregnancy - Maternity Services and Complications of Pregnancy</b>		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
	For services provided in the Physician's Office, a Copayment will only apply to the initial office visit.	<i>Prior Authorization is required if Inpatient Stay exceeds 48 hours following an uncomplicated normal vaginal delivery or 96 hours following an uncomplicated cesarean section delivery.</i>

## ADDITIONAL CORE BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
<b>Prosthetic Devices and Orthotic Devices</b>		
<p>Benefits are limited as follows:</p> <p>\$2,500 per year and are limited to a single purchase of each type of prosthetic device every three years.</p> <p>Once this limit is reached, Benefits, including breast prosthetics, continue to be available for items required by the Women's Health and Cancer Rights Act of 1998. Breast prosthetics are not limited, however the cost of breast prosthetics is applied to the maximum.</p>	100% after Deductible has been met.	70% after Deductible has been met.
<p>This benefit category contains services/devices that may be Essential or non-Essential Health Benefits as defined by the Patient Protection and Affordable Care Act depending upon the service or device delivered. A benefit review will take place once the dollar limit is exceeded. If the service/device is determined to be rehabilitative or habilitative in nature, it is an Essential Health Benefit and will be paid. If the benefit/device is determined to be non-essential, the maximum will have been met and the claim will not be paid.</p>		
<b>Prosthetic Devices and Orthotic Devices - Artificial Arms and Legs</b>		
<p>Benefits are limited to a single purchase of each type of prosthetic or orthotic device every three years.</p>	100% after Deductible has been met.	70% after Deductible has been met.
<b>Reconstructive Procedures</b>		
<p>For Covered Persons under the age of 18, Benefits are provided for the reconstructive procedures for craniofacial abnormalities.</p>	<p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.</p>	
<p><i>Prior Authorization is required.</i></p>		
<b>Rehabilitation Services - Outpatient Therapy and Manipulative Treatment</b>		
<p>Benefits are limited as follows:</p> <ul style="list-style-type: none"> <li>20 visits of Manipulative Treatments</li> <li>20 visits of physical therapy</li> <li>20 visits of occupational therapy</li> <li>20 visits of speech therapy</li> <li>20 visits of pulmonary rehabilitation</li> <li>36 visits of cardiac rehabilitation</li> <li>30 visits of post-cochlear implant aural therapy</li> <li>20 visits of cognitive rehabilitation therapy</li> </ul>	100% after you pay a \$35 Copayment per visit.	70% after Deductible has been met.
<p><i>Prior Authorization is required for Manipulative Treatment.</i></p>		
<b>Scopic Procedures - Outpatient Diagnostic and Therapeutic</b>		
<p>Diagnostic scopic procedures include, but are not limited to:</p> <ul style="list-style-type: none"> <li>Colonoscopy</li> <li>Sigmoidoscopy</li> <li>Endoscopy</li> </ul>	100% after Deductible has been met.	70% after Deductible has been met.
<p>For Preventive Scopic Procedures, refer to the Preventive Care Services category.</p>		

**ADDITIONAL CORE BENEFITS****YOUR BENEFITS**

Types of Coverage	Network Benefits	Non-Network Benefits
<b>Skilled Nursing Facility / Inpatient Rehabilitation Facility Services</b>		
Benefits are limited as follows: 60 days per year	100% after Deductible has been met.	70% after Deductible has been met.  <i>Prior Authorization is required.</i>
<b>Surgery - Outpatient</b>		
	100% after Deductible has been met.	70% after: Per Occurrence Deductible of \$250 and Annual Deductible have been met.  <i>Prior Authorization is required for certain services.</i>
<b>Therapeutic Treatments - Outpatient</b>		
Therapeutic treatments include, but are not limited to: Dialysis Intravenous chemotherapy or other intravenous infusion therapy Radiation oncology	100% after Deductible has been met.	70% after Deductible has been met.  <i>Prior Authorization is required for certain services.</i>
<b>Transplantation Services</b>		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Services category in this Benefit Summary.  For Network Benefits, services must be received at a Designated Facility. We will refer you to the Designated Facility most suitable, in our opinion, to treat your condition. In the event that the selected Designated Facility is located outside of Texas and you do not wish to travel outside the state, we shall refer you to an alternate Designated Facility within the State of Texas. We do not require that cornea transplants be performed at a Designated Facility in order for you to receive Network Benefits.  <i>Prior Authorization is required.</i>	Benefits are limited to \$30,000 per Transplant.  <i>Prior Authorization is required.</i>
<b>Vision Examinations</b>		
Benefits are limited as follows: 1 exam every 2 years	100% after you pay a \$35 Copayment per visit.	70% after Deductible has been met.

## STATE MANDATED BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
<b>Acquired Brain Injury</b>		
Outpatient Post-acute Transition Services and Post-acute Care Treatment Services: See the section for Rehabilitative Services - Outpatient Therapy and Manipulative Treatment in this benefit summary for physical therapy, occupational therapy, Manipulative Treatment and speech therapy limits.	100% after you pay a \$35 Copayment per visit.	70% after Deductible has been met.
Inpatient Post-acute Transition Services and Post-acute Care Treatment Services: Benefits are limited as follows: 60 days per year.	Benefits will be the same as those stated under the Hospital - Inpatient Stay category in this benefit summary.	
For all other Covered Health Services: Coverage for acquired brain injury will be the same as those stated under each Covered Health Service category in this Benefit Summary. Covered Health Services for Post-acute Care Treatment Services and Post-acute Transition Services are the same as any other illness or injury and subject to limits as stated under each category in this Benefit Summary.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
<i>Prior Authorization is required as described in your Schedule of Benefits.</i>		
<b>Acupuncture</b>		
Benefits are limited as follows: 20 visits per year.	100% after you pay a \$20 Copayment per visit.	70% after Deductible has been met.
<b>Amino Acid-Based Elemental Formulas</b>		
If an Outpatient Prescription Drug Rider is included under this Policy, Benefits for the amino acid-based elemental formulas will be provided as described under the Outpatient Prescription Drug Rider. Benefits will be provided as specified under this Benefit category: If there is not an Outpatient Prescription Drug Rider included under the policy or if any medically necessary services are provided in connection with the administration of the formula.	100% after Deductible has been met.	70% after Deductible has been met.
<i>Prior Authorization is required.</i>		
<b>Clinical Trials</b>		
Participation in a qualifying clinical trial for the treatment of: Cancer Cardiovascular (cardiac/stroke) Surgical musculoskeletal disorders of the spine, hip and knees	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
<i>Prior Authorization is required.</i>		<i>Prior Authorization is required.</i>

Types of Coverage	Network Benefits	Non-Network Benefits
<b>Developmental Delay Services (For Groups of 51 or more employees)</b>		
Benefits are paid at the same level as Benefits for any other Covered Health Service, except that the Benefit limit for Rehabilitation Services - Outpatient Therapy and Manipulative Treatment does not apply to services for developmental delays.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
<b>Mental Health Services</b>		
For groups with 50 or less total employees: Benefits are limited as follows:	For groups with 50 or less total employees:	For groups with 50 or less total employees:
15 days per year for Inpatient 20 visits per year for Outpatient	Inpatient: 100% after Deductible has been met.  Outpatient: 100% after you pay a \$70 Copayment per visit.	Inpatient: 70% after Deductible has been met.  Outpatient: 70% after Deductible has been met.
For groups with 51 or more total employees: Benefit limits do not apply	For groups with 51 or more total employees: Inpatient: 100% after Deductible has been met.  Outpatient: 100% after you pay a \$70 Copayment per visit.	For groups with 51 or more total employees: Inpatient: 70% after Deductible has been met.  Outpatient: 70% after Deductible has been met.
<i>Prior Authorization is required for certain services.</i>		
<b>Neurobiological Disorders – Autism Spectrum Disorder Services</b>		
	For groups with 50 or less total employees: Inpatient: 100% after Deductible has been met.  Outpatient: 100% after you pay a \$70 Copayment per visit.	For groups with 50 or less total employees: Inpatient: 70% after Deductible has been met.  Outpatient: 70% after Deductible has been met.
	For groups with 51 or more total employees: Inpatient: 100% after Deductible has been met.  Outpatient: 100% after you pay a \$70 Copayment per visit.	For groups with 51 or more total employees: Inpatient: 70% after Deductible has been met.  Outpatient: 70% after Deductible has been met.
<i>Prior Authorization is required for certain services.</i>		

**STATE MANDATED BENEFITS**

Types of Coverage	Network Benefits	Non-Network Benefits
<b>Substance Use Disorder Services (includes Chemical Dependency services as required under State of Texas insurance law and/or regulation)</b>		
<p>For groups with 50 or less total employees:</p> <p>Benefits for Chemical Dependency services are limited to a maximum of three Series of Treatments during the entire period of time a Covered Person is enrolled under the Policy. This limit does not apply to physical detoxification necessary to protect your physical health and well-being.</p>	<p>For groups with 50 or less total employees:</p> <p>Inpatient: 100% after Deductible has been met.</p> <p>Outpatient: 100% after you pay a \$70 Copayment per visit.</p>	<p>For groups with 50 or less total employees:</p> <p>Inpatient: 70% after Deductible has been met.</p> <p>Outpatient: 70% after Deductible has been met.</p>
<p>For groups with 51 or more total employees: Benefit limits do not apply</p>	<p>For groups with 51 or more total employees:</p> <p>Inpatient: 100% after Deductible has been met.</p> <p>Outpatient: 100% after you pay a \$70 Copayment per visit.</p>	<p>For groups with 51 or more total employees:</p> <p>Inpatient: 70% after Deductible has been met.</p> <p>Outpatient: 70% after Deductible has been met.</p> <p><i>Prior Authorization is required for certain services.</i></p>
<b>Temporomandibular Joint Services (For Groups of 51 or more employees)</b>		
<p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.</p> <p><i>Request for Pre-authorization of Services required.</i></p>		

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## MEDICAL EXCLUSIONS

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It is recommended that you review your COC for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

### Alternative Treatments

Acupressure; aromatherapy; hypnotism; massage therapy; rolfing; art therapy, music therapy, dance therapy, horseback therapy; and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in Section 1 of the COC.

### Dental

Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia). This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only in Section 1 of the COC. This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Policy, limited to: Transplant preparation; prior to initiation of immunosuppressive drugs; the direct treatment of acute traumatic Injury, cancer or cleft palate. Services required by a Covered Person who is unable to undergo dental treatment in an office setting or under local anesthesia because of a documented physical, mental or medical reason. Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication. Endodontics, periodontal surgery and restorative treatment are excluded. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include: extraction, restoration and replacement of teeth; medical or surgical treatments of dental conditions; and services to improve dental clinical outcomes. This exclusion does not apply to accidental-related dental services for which Benefits are provided as described under Dental Services - Accidental Only in Section 1 of the COC. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only in Section 1 of the COC. Dental braces (orthodontics). Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly.

### Devices, Appliances and Prosthetics

Devices used specifically as safety items or to affect performance in sports-related activities. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. This exclusion does not apply to orthotic devices as described under Prosthetic Devices and Orthotic Devices - Artificial Arms and Legs in Section 1 of the COC. Cranial banding. The following items are excluded, even if prescribed by a Physician: blood pressure cuff/monitor; enuresis alarm; non-wearable external defibrillator; trusses and ultrasonic nebulizers. Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under Durable Medical Equipment in Section 1 of the COC. Oral appliances for snoring. Repairs to prosthetic or orthotic devices due to misuse, malicious damage or gross neglect. Replacement of prosthetic or orthotic devices due to misuse, malicious damage or gross neglect or to replace lost items.

### Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill. This exclusion does not apply to prescription and non-prescription oral agents for controlling blood sugar levels. Note: If an Outpatient Prescription Drug Rider is included under the Policy, Benefits for the prescription and non-prescription oral agents will be provided under the Outpatient Prescription Drug Rider. Otherwise, the Benefits will be provided under the Certificate. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to self-injectable medications for which Benefits are provided as described under Diabetes Services in Section 1 of the COC. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office. Over-the-counter drugs and treatments. This exclusion does not apply to over-the-counter drugs and treatments for which Benefits are provided as described under Diabetes Services in Section 1 of the COC. Growth hormone therapy.

### Experimental, Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in Section 1 of the COC.

## MEDICAL EXCLUSIONS CONTINUED

### Foot Care

Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under Diabetes Services in Section 1 of the COC. Nail trimming, cutting, or debriding. Hygienic and preventive maintenance foot care. Examples include: cleaning and soaking the feet; applying skin creams in order to maintain skin tone. This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes. Treatment of flat feet. Treatment of subluxation of the foot. Shoes. Shoe orthotics. This exclusion does not apply to podiatric appliances or therapeutic footwear as described under Diabetes Services or Prosthetic Devices and Orthotic Devices - Artificial Arms and Legs in Section 1 of the COC. Shoe inserts and arch supports.

### Medical Supplies

Prescribed or non-prescribed medical supplies and disposable supplies. Examples include: compression stockings, ace bandages, gauze and dressings, urinary catheters. This exclusion does not apply to:

- Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under Durable Medical Equipment in Section 1 of the COC.
- Diabetic supplies for which Benefits are provided as described under Diabetes Services in Section 1 of COC.
- Ostomy supplies for which Benefits are provided as described under Ostomy Supplies in Section 1 of the COC.

Tubing and masks, except when used with Durable Medical Equipment as described under Durable Medical Equipment in Section 1 of the COC.

### Mental Health

Services performed in connection with "Serious Mental Illnesses" as defined in Section 9 of the COC. Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Mental Health Services as treatments for V-code conditions as listed within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning. Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act. Learning, motor skills, and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Mental retardation and autism spectrum disorder as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Please Note: This Mental Health exclusion section excludes Autism Spectrum Disorders because treatment for Autism Spectrum Disorders are not covered/provided under the Mental Health Services benefit section of Section 1: Covered Health Services. Instead, Benefits for Autism Spectrum Disorder as a primary diagnosis are described under Neurobiological Disorders - Autism Spectrum Disorder Services in Section 1 of the COC. Services or supplies for the diagnosis or treatment of Mental Illness that, in our reasonable judgment, are any of the following:

- Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
- Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
- Not consistent with our level of care guidelines or best practices as modified from time to time.
- Not clinically appropriate for the patient's Mental Illness or condition based on generally accepted standards of medical practice and benchmarks.

### Neurobiological Disorders – Autism Spectrum Disorders

Services as treatments of sexual dysfunction and feeding disorders as listed in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services. Mental retardation as the primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act. Services as treatment of learning, motor skills and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association and which are not a part of Autism Spectrum Disorder. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias. Services or supplies for the diagnosis or treatment of Mental Illness that, in our reasonable judgment, are any of the following:

- Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
- Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
- Not consistent with our level of care guidelines or best practices as modified from time to time.
- Not clinically appropriate for the patient's Mental Illness or condition based on generally accepted standards of medical practice and benchmarks.

## MEDICAL EXCLUSIONS CONTINUED

### Nutrition

Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:

- Nutritional education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Enteral feedings, even if the sole source of nutrition. This exclusion does not apply to amino acid-based elemental formulas as described under Amino Acid-Based Elemental Formulas in Section 1 of the COC. Infant formula and donor breast milk. This exclusion does not apply to amino acid-based elemental formulas as described under Amino Acid-Based Elemental Formulas in Section 1 of the COC. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods). This exclusion does not apply to:

- Nutritional supplements for the treatment of Autism Spectrum Disorders, as described in Section 1 of the COC, which meet the definition of a Covered Health Service.
- Amino acid-based elemental formulas as described under Amino Acid-Based Elemental Formulas in Section 1 of the COC.
- Formulas for phenylketonuria (PKU) or other heritable diseases.

### Personal Care, Comfort or Convenience

Television; telephone; beauty/barber service; guest service. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include: air conditioners, air purifiers and filters, dehumidifiers; batteries and battery chargers; breast pumps; car seats; chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners; exercise equipment; home modifications such as elevators, handrails and ramps; hot tubs; humidifiers; Jacuzzis; mattresses; medical alert systems; motorized beds; music devices; personal computers, pillows; power-operated vehicles; radios; saunas; stair lifts and stair glides; strollers; safety equipment; treadmills; vehicle modifications such as van lifts; video players, whirlpools.

### Physical Appearance

Cosmetic Procedures. See the definition in Section 9 of the COC. Examples include: pharmacological regimens, nutritional procedures or treatments. Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). Skin abrasion procedures performed as a treatment for acne. Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. Treatment for skin wrinkles or any treatment to improve the appearance of the skin. Treatment for spider veins. Hair removal or replacement by any means. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See Reconstructive Procedures in Section 1 of the COC. Treatment of benign gynecomastia (abnormal breast enlargement in males). Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded. Wigs regardless of the reason for the hair loss.

### Procedures and Treatments

Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, and brachioplasty. Medical and surgical treatment of excessive sweating (hyperhidrosis). Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. Rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly or Autism Spectrum Disorders. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident. Psychosurgery. Sex transformation operations and related services. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter. Biofeedback. This exclusion does not apply when the service is rendered with the diagnosis of acquired brain injury. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea. Surgical and non-surgical treatment of obesity. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings. Breast reduction except as coverage is required by the Women's Health and Cancer Right's Act of 1998 for which Benefits are described under Reconstructive Procedures in Section 1 of the COC. In vitro fertilization regardless of the reason for treatment.

## MEDICAL EXCLUSIONS CONTINUED

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### Providers

Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. This exclusion does not apply to dentists. Services performed by a provider with your same legal residence. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider has not been actively involved in your medical care prior to ordering the service, or is not actively involved in your medical care after the service is received. This exclusion does not apply to mammography.

### Reproduction

Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility. Surrogate parenting, donor eggs, donor sperm and host uterus. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue. The reversal of voluntary sterilization.

### Services Provided under Another Plan

Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation. If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness, or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.

### Substance Use Disorders

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning. Services or supplies for the diagnosis or treatment of alcoholism or substance use disorders that, in our reasonable judgment, are any of the following:

- Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
- Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
- Not consistent with our level of care guidelines or best practices as modified from time to time.
- Not clinically appropriate for the patient's substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.

### Transplants

Health services for organ and tissue transplants, except those described under Transplantation Services in Section 1 of the COC. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.) Health services for transplants involving permanent mechanical or animal organs.

### Travel

Health services provided in a foreign country, unless required as Emergency Health Services. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under Ambulance Services in Section 1 of the COC.

### Types of Care

Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain. Custodial care or maintenance care; domiciliary care. Private Duty Nursing. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under Hospice Care in Section 1 of the COC. Rest cures; services of personal care attendants. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

## MEDICAL EXCLUSIONS CONTINUED

### Vision and Hearing

Purchase cost and fitting charge for eye glasses and contact lenses. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants). Eye exercise or vision therapy. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser, and other refractive eye surgery.

Bone anchored hearing aids except when either of the following applies: For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid. For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. More than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled under the Policy. Repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage criteria, other than for malfunctions.

### All Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 9 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following: Medically Necessary; described as a Covered Health Service in Section 1 of the COC and Schedule of Benefits; and not otherwise excluded in Section 2 of the COC. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when: required solely for purposes of school, sports or camp, travel, career or employment, insurance, marriage or adoption; related to judicial or administrative proceedings or orders; conducted for purposes of medical research (This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in Section 1 of the COC); required to obtain or maintain a license of any type. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians Injured or otherwise affected by war, any act of war, or terrorism in non-war zones. Health services received after the date your coverage under the Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Policy ended. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy. In the event a non-Network provider waives Copayments, Coinsurance and/or any deductible for a particular health service, no Benefits are provided for the health service for which the Copayments, Coinsurance and/or deductible are waived. Charges in excess of Eligible Expenses or in excess of any specified limitation. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products. Autopsy. Foreign language and sign language services. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service. For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

### Preexisting Conditions (Applies only to groups of 50 or less employees)

Preexisting Condition - an injury or Sickness that was diagnosed, treated, or prescription medications or drugs were prescribed or taken within the predefined period prior to the enrollment date or, if earlier, the first day of any waiting period. This does not include Pregnancy. Genetic information is not an indicator of a Preexisting Condition, if there is not a diagnosis of a condition related to the genetic information.

Preexisting Conditions - Benefits for the treatment of a Preexisting Condition are excluded until the date you have had Continuous Creditable Coverage for 12 months. This exclusion does not apply to newborn children, newly adopted children or children placed for adoption. This exception for newborn, adopted children and children placed for adoption no longer applies after the end of the first 63-day period during which the child has not had Continuous Creditable Coverage. This exclusion does not apply to Covered Persons under age 19.

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