UnitedHealthcare®

YOUR BENEFITS

Benefit Summary

Virginia - Choice Plus
Choice Plus Direct - PLT CP #1 RX-C (CW7) Plan CW7

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®** - 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
Annual Deductible		
Individual Deductible	$250 per year	$2,000 per year
Family Deductible	$500 per year	$4,000 per year

> Copayments do not accumulate towards the Deductible unless otherwise notated within the specific Benefit category below.

> All individual Deductible amounts will count toward the family Deductible, but an individual will not have to pay more than the individual Deductible amount.

> 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.

Out-of-Pocket Maximum		
Individual Out-of-Pocket Maximum	$3,000 per year	$6,000 per year
Family Out-of-Pocket Maximum	$6,000 per year	$12,000 per year

> 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.

> Copayments, Coinsurance, Deductibles and Per Occurrence Deductibles accumulate towards the Out-of-Pocket Maximum.

Pediatric Vision Care Services Deductible		
Individual Deductible	Vision Care Services are included in Annual Deductible.	Vision Care Services are included in Annual Deductible.
Family Deductible	Vision Care Services are included in Annual Deductible.	Vision Care Services are included in Annual Deductible.

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), Riders, and/or Amendments, those documents shall prevail. It is recommended that you review these documents 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.

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UnitedHealthcare Insurance Company

Prescription Drug Benefits

Prescription drug benefits are shown under separate cover.

Additional Benefit Information

> Refer to your Certificate of Coverage or Summary of Benefits and Coverage to determine if the Annual Deductible, Out-of-Pocket Maximum and Benefit limits are calculated on a Policy or Calendar year basis.

> Refer to your Certificate of Coverage and your Riders for the definition of Eligible Expenses and information on how Benefits are paid. In order to obtain the highest level of Benefits, you should confirm the Network status of all providers prior to obtaining Covered Health Services.

> 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
Physician's Office Services - Sickness and Injury		
Primary Physician Office Visit	100% after you pay a $15 Copayment per visit.	70% after Deductible has been met.
Specialist Physician Office Visit	100% after you pay a $30 Copayment per visit.	70% after Deductible has been met. *Prior Authorization is required for Genetic Testing - BRCA.*

> In addition to the office visit Copayment stated in this section, the Copayment/Coinsurance and any deductible applies when these services are done: Lab, X-Ray; CT, PET, MRI, MRA, Nuclear Medicine; Pharmaceutical Products, Scopic Procedures; Surgery; Therapeutic Treatments.

Preventive Care Services		
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.	

The health care reform law provides for coverage of certain preventive services, based on your age, gender and other health factors, with no cost-sharing. The preventive care services covered under this section are those preventive services specified in the health care reform law. UnitedHealthcare also covers other routine services as described in other areas of this summary, which may require a copayment, coinsurance or deductible. Always refer to your plan documents for your specific coverage.

Urgent Care Center Services		
	100% after Deductible has been met.	70% after Deductible has been met.
Emergency Health Services - Outpatient		
	100% after Deductible has been met.	100% after Network Deductible has been met. *Notification is required if confined in a non-Network Hospital.*

Types of Coverage	Network Benefits	Non-Network Benefits
Hospital - Inpatient Stay		
	100% after Deductible has been met.	70% after Deductible has been met. *Prior Authorization is required.*

ADDITIONAL CORE BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Ambulance Service - Emergency and Non-Emergency		
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.
	Prior Authorization is required for non-Emergency Ambulance.	*Prior Authorization is required for non-Emergency Ambulance.*
Congenital Heart Disease (CHD) Surgeries		
	100% after Deductible has been met.	70% after Deductible has been met.
		Prior Authorization is required.
Dental Services - Accident Only		
	100% after Deductible has been met.	100% after Network Deductible has been met.
	Prior Authorization is required.	*Prior Authorization is required.*
Diabetes Services		
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	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.	
		Prior Authorization is required for Durable Medical Equipment in excess of $1,000.
Durable Medical Equipment		
	100% after Deductible has been met.	70% after Deductible has been met.
		Prior Authorization is required for Durable Medical Equipment in excess of $1,000.
Habilitative Services		
	Benefits for Habilitative Services are provided under and as part of Rehabilitation Services – Outpatient Therapy and Manipulative Treatment and are subject to the limits as stated below in this benefit summary.	
Hearing Aids		
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.

Types of Coverage	Network Benefits	Non-Network Benefits
Home Health Care		
Benefits are limited as follows: 100 visits per year for Home Health Care 2 visits per year for Private Duty Nursing In accordance with Virginia law and as described in the Certificate of Coverage, Benefits are provided for one home visit for a newborn following obstetrical care in a Hospital and an additional newborn home visit, as prescribed by a Physician. Such visits are not subject to the above annual limits.	100% after Deductible has been met.	70% after Deductible has been met. *Prior Authorization is required.*
Hospice Care		
	100% after Deductible has been met.	70% after Deductible has been met. *Prior Authorization is required for Inpatient Stay.*
Lab, X-Ray and Diagnostics - Outpatient		
For Preventive Lab, X-Ray and Diagnostics, refer to the Preventive Care Services category.		
Lab Testing - Outpatient	Free-standing lab or in a Physician's office 100% after Deductible has been met. Hospital-based lab 100% after Deductible has been met.	Free-standing lab or in a Physician's office 70% after Deductible has been met. Hospital-based lab 70% after Deductible has been met.
X-Ray and Other Diagnostic Testing - Outpatient	Free-standing diagnostic center or in a Physician's office 100% after Deductible has been met. Outpatient Hospital-based diagnostic center 100% after Deductible has been met.	Free-standing diagnostic center or in a Physician's office 70% after Deductible has been met. Outpatient Hospital-based diagnostic center 70% after Deductible has been met. *Prior Authorization is required for sleep studies.*
Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient		
	Free-standing diagnostic center or in a Physician's office 100% after Deductible has been met. Outpatient Hospital-based diagnostic center 100% after: Per Occurrence Deductible of $250 per service and Annual Deductible have been met.	Free-standing diagnostic center or in a Physician's office 70% after Deductible has been met. Outpatient Hospital-based diagnostic center 70% after: Per Occurrence Deductible of $250 per service and Annual Deductible have been met. *Prior Authorization is required.*
Ostomy Supplies		
	100% after Deductible has been met.	70% after Deductible has been met.

ADDITIONAL CORE BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Pediatric Vision Services (Benefits covered up to age 19)		
You may access a listing of Spectera Eyecare Networks Vision Care Providers on the Internet at www.myuhcvision.com.		
Routine Vision Examination Benefits are limited to once per year.	100% after you pay a $15 copay.	50% after Deductible has been met.
Eyeglass Lenses Benefits are limited to once per year. Coverage includes polycarbonate lenses and standard scratch-resistant coating.	50% Deductible does not apply.	50% after Deductible has been met.
Eyeglass Frames Benefits are limited to once per year.		
Eyeglass frames with a retail cost up to $130.	50% Deductible does not apply.	50% after Deductible has been met.
Eyeglass frames with a retail cost of $130 - 160.	50% Deductible does not apply.	50% after Deductible has been met.
Eyeglass frames with a retail cost of $160 - 200.	50% Deductible does not apply.	50% after Deductible has been met.
Eyeglass frames with a retail cost of $200 - 250.	50% Deductible does not apply.	50% after Deductible has been met.
Eyeglass frames with a retail cost greater than $250.	50% Deductible does not apply.	50% after Deductible has been met.
Contact Lenses/Necessary Contact Lenses Benefits are limited to a 12 month supply. Contacts are in lieu of Frames and Lenses. Reference www.myuhcvision.com for a complete list of covered contacts.	50% Deductible does not apply.	50% after Deductible has been met.
Low Vision Services Benefits are limited to a 24 month frequency, or every 6 months when low vision conditions occur.	100% for Low Vision Testing. 75% for Low Vision Therapy.	75% after Deductible has been met for Low Vision Testing. 75% after Deductible has been met for Low Vision Therapy.
Pharmaceutical Products - Outpatient		
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.
Physician Fees for Surgical and Medical Services		
	100% after Deductible has been met.	70% after Deductible has been met.
Pregnancy - Maternity Services		
	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.	
		Prior Authorization is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.
Prosthetic Devices		
	100% after Deductible has been met.	70% after Deductible has been met. *Prior Authorization is required for Prosthetic Devices in excess of $1,000.*

Types of Coverage	Network Benefits	Non-Network Benefits
Reconstructive Procedures		
	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.	
		Prior Authorization is required.
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment		
Benefits are limited as follows: 30 visits of Manipulative Treatments 30 visits of speech therapy 20 visits of pulmonary rehabilitation 30 visits of post-cochlear implant aural therapy 20 visits of cognitive rehabilitation therapy 30 visits of physical therapy and occupational therapy combined	100% after you pay a $15 Copayment per visit.	70% after Deductible has been met.
		Prior Authorization is required for certain services.
Scopic Procedures - Outpatient Diagnostic and Therapeutic		
Diagnostic scopic procedures include, but are not limited to: Colonoscopy Sigmoidoscopy Endoscopy For Preventive Scopic Procedures, refer to the Preventive Care Services category.	Free-standing center or in a Physician's office 100% after Deductible has been met. Outpatient Hospital-based center 100% after: Per Occurrence Deductible of $250 per date of service and Annual Deductible have been met.	Free-standing center or in a Physician's office 70% after Deductible has been met. Outpatient Hospital-based center 70% after: Per Occurrence Deductible of $250 per date of service and Annual Deductible have been met.
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services		
Benefits are limited as follows: 100 days per stay	100% after Deductible has been met.	70% after Deductible has been met.
		Prior Authorization is required.
Surgery - Outpatient		
	Ambulatory surgical center or in a Physician's office 100% after Deductible has been met. Outpatient Hospital-based surgical center 100% after: Per Occurrence Deductible of $250 per date of service and Annual Deductible have been met.	Ambulatory surgical center or in a Physician's office 70% after Deductible has been met. Outpatient Hospital-based surgical center 70% after: Per Occurrence Deductible of $250 per date of service and Annual Deductible have been met. *Prior Authorization is required for certain services.*
Therapeutic Treatments - Outpatient		
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. *Prior Authorization is required for certain services.*

ADDITIONAL CORE BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Transplantation Services		
	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 Network Benefits, services must be received at a Designated Facility. *Prior Authorization is required.*	*Prior Authorization is required.*
Routine Vision Examinations (Benefit is for Covered Persons over age 19)		
You may access a listing of Spectera Eyecare Networks Vision Care Providers on the Internet at www.myuhcvision.com. Benefits are limited as follows: 1 exam per year	100% after you pay a $15 copay per visit.	50% after Deductible has been met.

Types of Coverage	Network Benefits	Non-Network Benefits
Cleft Lip and Cleft Palate Treatment		
	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.	
	Prior Authorization is required as described in your Schedule of Benefits.	*Prior Authorization is required as described in your Schedule of Benefits.*
Clinical Trials		
Participation in a qualifying clinical trial for the treatment of: Cancer or other life-threatening disease or condition 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.	
	Prior Authorization is required.	*Prior Authorization is required.*
Congenital Defects and Birth Abnormalities		
	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.	
	Prior Authorization is required as described in your Schedule of Benefits.	*Prior Authorization is required as described in your Schedule of Benefits.*
Dental Anesthesia and Facility Services		
	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.	
		Prior Authorization is required.
Early Intervention Services		
	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.	
Home Treatment of Hemophilia and Congenital Bleeding Disorders		
	Depending upon where the Covered Health Service is provided, Benefits for blood infusion equipment and blood products will be the same as those stated under Durable Medical Equipment, Pharmaceutical Products - Outpatient, or in the Outpatient Prescription Drug Rider.	
		Pre-service Notification is required.
Medical Formulas		
	100% after Deductible has been met.	70% after Deductible has been met.
		Prior Authorization is required.
Mental Health Services		
When outpatient visits are subject to payment of a Copayment, the Copayment will not exceed 50% of Eligible Expenses.	Inpatient: 100% after Deductible has been met.	Inpatient: 70% after Deductible has been met.
	Outpatient: 100% after you pay a $30 Copayment per visit.	Outpatient: 70% after Deductible has been met.
		Prior Authorization is required for certain services.

STATE SPECIFIC BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Neurobiological Disorders – Autism Spectrum Disorder Services		
When outpatient visits are subject to payment of a Copayment, the Copayment will not exceed 50% of Eligible Expenses.	Inpatient: 100% after Deductible has been met. Outpatient: 100% after you pay a $30 Copayment per visit.	Inpatient: 70% after Deductible has been met. Outpatient: 70% after Deductible has been met. *Prior Authorization is required for certain services.*
Oral Surgery		
	100% after Deductible has been met. *Prior Authorization is required.*	70% after Deductible has been met. *Prior Authorization is required.*
Substance Use Disorder Services		
When outpatient visits are subject to payment of a Copayment, the Copayment will not exceed 50% of Eligible Expenses.	Inpatient: 100% after Deductible has been met. Outpatient: 100% after you pay a $30 Copayment per visit.	Inpatient: 70% after Deductible has been met. Outpatient: 70% after Deductible has been met. *Prior Authorization is required for certain services.*
Temporomandibular Joint Services		
	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.	*Prior Authorization is required for Inpatient Stay.*

Types of Coverage	Network Benefits	Non-Network Benefits
Pediatric Dental Services Deductible (Benefits covered up to age 19)		
Individual Deductible	Dental Services Deductible is included in Annual Deductible.	Dental Services Deductible is included in Annual Deductible.
Family Deductible	Dental Services Deductible is included in Annual Deductible.	Dental Services Deductible is included in Annual Deductible.
Preventive Services		
Dental Prophylaxis (Cleanings) Benefits are limited to: 2 times per 12 months.	100% after Deductible has been met.	100% after Deductible has been met.
Fluoride Treatments Benefits are limited to: 2 times per 12 months.	100% after Deductible has been met.	100% after Deductible has been met.
Sealants (Protective Coating) Benefits are limited to: Once per first or second permanent molar every 36 months.	100% after Deductible has been met.	100% after Deductible has been met.
Space Maintainers Benefits are limited to: 1 per 60 months. Benefit includes all adjustments within 6 months of installation.	100% after Deductible has been met.	100% after Deductible has been met.
Diagnostic Services		
Periodic Oral Evaluation (Check-up Exam) Benefits are limited to: 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	100% after Deductible has been met.	100% after Deductible has been met.
Radiographs Benefits are limited to: 2 series of films per 12 months for Bitewing. 1 time per 36 months for Complete/ Panorex.	100% after Deductible has been met.	100% after Deductible has been met.

PEDIATRIC DENTAL SERVICES BENEFIT

Types of Coverage	Network Benefits	Non-Network Benefits
Basic Dental Services		
Endodontics (Root Canal Therapy) Benefits are limited to: 1 time per tooth per lifetime.	80% after Deductible has been met.	80% after Deductible has been met.
General Services (Including Emergency treatment) Palliative Treatment: Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General Anesthesia: Covered when clinically necessary. Occlusal Guard: Benefits are limited to: 1 guard every 12 months and only covered if prescribed to control habitual grinding.	80% after Deductible has been met.	80% after Deductible has been met.
Oral Surgery (Including Surgical Extractions)	80% after Deductible has been met.	80% after Deductible has been met.
Periodontics Periodontal Surgery: Benefits are limited to: 1 quadrant or site per 36 months per surgical area. Scaling and Root Planing: Benefits are limited to: 1 time per quadrant per 24 months. Periodontal Maintenance: Benefits are limited to: 2 times per 12 months following active and adjunctive periodontal therapy, exclusive of gross debridement.	80% after Deductible has been met.	80% after Deductible has been met.
Restorations (Amalgam or Anterior Composite) Multiple restorations on one surface will be treated as one filling.	80% after Deductible has been met.	80% after Deductible has been met.
Simple Extractions (Simple tooth removal) Benefits are limited to: 1 time per tooth per lifetime.	80% after Deductible has been met.	80% after Deductible has been met.

Types of Coverage	Network Benefits	Non-Network Benefits
Major Restorative Services		
Inlays/Onlays/Crowns (Partial to Full Crowns) Benefits are limited to: 1 time per tooth per 60 months.	50% after Deductible has been met.	50% after Deductible has been met.
Dentures and other removable Prosthetics (Full denture/partial denture) Benefits are limited to: 1 time per 60 months.	50% after Deductible has been met.	50% after Deductible has been met.
Fixed Partial Dentures (Bridges) Benefits are limited to: 1 time per tooth per 60 months.	50% after Deductible has been met.	50% after Deductible has been met.
Implants Benefits are limited to: 1 time per tooth per 60 months.	50% after Deductible has been met.	50% after Deductible has been met.
Medically Necessary Orthodontics		
Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/ overbite) discrepancies.	50% after Deductible has been met. *Prior Authorization required for orthodontic treatment.*	50% after Deductible has been met. *Prior Authorization required for orthodontic treatment.*

EXCLUSIONS

It is recommended that you review your COC, Amendments and Riders 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; acupuncture; 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 (For Pediatric Dental, see below)

Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia) except as specifically described under Dental Anesthesia and Facility Services in Section 1 of the COC or 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, cleft lip, cleft palate or ectodermal dysplasia. 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). This exclusion does not apply to cleft lip/palate or ectodermal dysplasia - related dental services for which Benefits are provided as described under Cleft Lip and Cleft Palate Treatment in Section 1 of the COC. Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly. Treatment of natural teeth due to accidental injury occurring on or after your effective date under the Policy when treatment was not sought within 60 days after the injury and approval not received from us.

Devices, Appliances and Prosthetics

Devices used specifically as safety items or to affect performance in sports-related activities. Foot orthotics and over-the-counter orthotic braces. Cranial banding except when Medically Necessary to correct a Congenital Anomaly. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiological function are considered Cosmetic Procedures. 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 unless Medically Necessary. If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the equipment that meets the minimum specifications for your needs. Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophogeal 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 devices due to misuse, malicious damage or gross neglect. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items. Appliances for temporomandibular joint syndrome (TMJ) pain dysfunction.

Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill. 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. 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. 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. This exclusion does not apply to any prescribed drug that has not been approved by the U.S. Food and Drug Administration (FDA) for the treatment of the specific condition for which the drug has been prescribed provided that both of the following criteria are met: The drug has been approved by the FDA for at least one indication. The drug has been recognized as safe and effective for the treatment of the specific condition in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature. This exclusion does not apply to any drug approved by the FDA for use in the treatment of cancer pain even if the dosage is in excess of the recommended dosage of the pain relieving agent, if the prescription in excess of the recommended dosage has been prescribed for a patient with intractable cancer pain.

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; 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 the COC.
- Blood infusion equipment for which Benefits are provided as described under Home Treatment of Hemophilia and Congenital Blood Disorders in Section 1 of the 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 conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Mental Health Services as treatments for R & T 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-wake disorders, feeding disorders, binge eating 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 paraphilic disorder. 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 disorders and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Intellectual disabilities and Autism Spectrum Disorder as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Benefits for Autism Spectrum Disorder as a primary diagnosis are described under Neurobiological Disorders - Autism Spectrum Disorder Services in Section 1 of the COC. Mental Health Services as a treatment for other conditions that may be a focus of clinical attention as listed in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. All unspecified disorders in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. 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 in the Schedule of Benefits.
- Not otherwise excluded in Section 2 of the COC.

Neurobiological Disorders – Autism Spectrum Disorder

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. Intellectual disability 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. Learning, motor disorders and 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 paraphilic disorder. All unspecified disorders in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorder. 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 in the Schedule of Benefits.
- Not otherwise excluded in Section 2 of the COC.

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 when not Medically Necessary. Infant formula and donor breast milk. 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).

Pediatric Dental Services

Benefits are not provided under the Pediatric Dental Services for the following: Any Dental Service or Procedure not listed as a Covered Pediatric Dental Service. Dental Services that are not Necessary. Hospitalization or other facility charges. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.) Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, Injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body. Any Dental Procedure not directly associated with dental disease. Any Dental Procedure not performed in a dental setting. Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. 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. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision. Replacement of complete dentures, fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice. Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled for coverage provided through the Rider to the Policy. Dental Services otherwise covered under the Policy, but rendered after the date individual coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy terminates. Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child. Foreign Services are not covered unless required as an Emergency. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO). Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan.

Pediatric Vision Services

Benefits are not provided under Pediatric Vision Services for the following: Medical or surgical treatment for eye disease which requires the services of a Physician and for which Benefits are available as stated in the COC. Non-prescription items (e.g. Plano lenses). Replacement or repair of lenses and/or frames that have been lost or broken. Optional Lens Extras not listed in Vision Care Services. Missed appointment charges. Applicable sales tax charged on Vision Care Services.

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 (This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement); 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 unless Medically Necessary. 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. Surgical treatment of gynecomastia for cosmetic purposes. 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. Physical therapy, occupational therapy or speech therapy to maintain or preserve current functions if there is no chance of improvement or reversal except as described under Early Intervention Services in Section 1 of the COC and as defined in Section 9 of the COC. Group speech therapy. 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. The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; appliances for TMJ pain dysfunction; and dental restorations. Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury, dislocation, tumors or cancer. Orthognathic surgery and jaw alignment, except as a treatment of obstructive sleep apnea. Orthognathic surgery except as described under Oral Surgery in Section 1 of the COC. 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 surgery except as coverage is required by the Women's Health and Cancer Rights 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.

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. 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 diagnose, 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, 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. Substance-induced sexual dysfunction disorders and substance-induced sleep disorders. Gambling disorders. All unspecified disorders in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. 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 in the Schedule of Benefits.
- Not otherwise excluded in Section 2 of the COC.

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 at our discretion. 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. This exclusion does not apply to Private Duty Nursing services as described under Private Duty Nursing - Home Services in Section 1 of the COC. 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).

Vision and Hearing (For Pediatric Vision, see above)

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.

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