UnitedHealthcare®

YOUR BENEFITS

Benefit Summary

Missouri - Choice Plus
HSA - 30/3000/100% Plan JUW Modified

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 - Combined Medical and Pharmacy		
Individual Deductible	$3,000 per year	$9,000 per year
Family Deductible	$6,000 per year	$18,000 per year
Out-of-Pocket Maximum - Combined Medical and Pharmacy		
Individual Out-of-Pocket Maximum	$6,250 per year	$12,500 per year
Family Out-of-Pocket Maximum	$12,500 per year	$25,000 per year
> Copayments, Coinsurance and Deductibles accumulate towards the Out-of-Pocket Maximum.		

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.

MOXG07JUW14 Modified

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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 a paid.

> 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 the Deductible has been met and you pay a $30 Copayment per visit.	70% after Deductible has been met.
Specialist Physician Office Visit	100% after the Deductible has been met and you pay a $60 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

Preventive Care Services

Covered Health Services include but are not limited to:

Primary Physician Office Visit You are not required to pay any Copayments or Coinsurance or meet any deductible for immunizations for Enrolled Dependent children from birth to age five.	100%, Copayments and Deductibles do not apply.	70% after Deductible has been met. 100% for child immunizations to age five.
Specialist Physician Office Visit You are not required to pay any Copayments or Coinsurance or meet any deductible for immunizations for Enrolled Dependent children from birth to age five.	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 the Deductible has been met and you pay a $75 Copayment per visit.	70% after Deductible has been met.

> In addition to the 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.

Types of Coverage	Network Benefits	Non-Network Benefits
Emergency Health Services - Outpatient		
	100% after the Deductible has been met and you pay a $300 Copayment per visit.	100% after the Network Deductible has been met and you pay a $300 Copayment per visit. *Notification is required if confined in a non-Network Hospital.*
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	Benefit level is based on the setting where each Covered Health Service is received. Examples include but are not limited to the following: Benefits for diabetic eye examinations performed in a Physician's office will be the same as found under Physician's Office Services - Sickness and Injury in this Benefit Summary. Benefits for a Physician's office visit associated with diabetes self-management and training will be the same as found under Physician's Office Services - Sickness and Injury in this Benefit Summary. Benefits for diabetic foot care for surgeries performed on an outpatient basis will be the same as found under Surgery - Outpatient in this Benefit Summary.	Benefit level is based on the setting where each Covered Health Service is received. Examples include but are not limited to the following: Benefits for diabetic eye examinations performed in a Physician's office will be the same as found under Physician's Office Services - Sickness and Injury in this Benefit Summary. Benefits for a Physician's office visit associated with diabetes self-management and training will be the same as found under Physician's Office Services - Sickness and Injury in this Benefit Summary. Benefits for diabetic foot care for surgeries performed on an outpatient basis will be the same as found under Surgery - Outpatient in this Benefit Summary.
Diabetes Self Management Items	Benefit level is based on the setting where each Covered Health Service is received. Examples include but are not limited to the following: Benefits for diabetes self-management Items related to Durable Medical Equipment will be the same as found under Durable Medical Equipment in this Benefit Summary. Benefits for diabetes self-management items related to prescribed items obtained at a pharmacy can be found in the Outpatient Prescription Drug Rider.	Benefit level is based on the setting where each Covered Health Service is received. Examples include but are not limited to the following: Benefits for diabetes self-management Items related to Durable Medical Equipment will be the same as found under Durable Medical Equipment in this Benefit Summary. Benefits for diabetes self-management items related to prescribed items obtained at a pharmacy can be found in the Outpatient Prescription Drug Rider. *Prior Authorization is required for Durable Medical Equipment in excess of $1,000.*

Types of Coverage	Network Benefits	Non-Network Benefits
Durable Medical Equipment		
Benefits are limited as follows: 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. To receive Network Benefits, you must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	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: $4,000 per year and a single purchase (including repair/ replacement) per hearing impaired ear every three years. The above limitation does not apply to Newborns.	100% after Deductible has been met.	70% after Deductible has been met.
Home Health Care		
Benefits are limited as follows: 90 visits per year This visit limit does not include any service which is billed only for the administration of intravenous infusion.	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	100% after Deductible has been met.	70% after Deductible has been met.
X-Ray and Other Diagnostic Testing - Outpatient	100% after Deductible has been met.	70% after Deductible has been met.
Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient		
	100% after Deductible has been met.	70% after Deductible has been met.

ADDITIONAL CORE BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Ostomy Supplies		
	100% after Deductible has been met.	70% after Deductible has been met.
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		
An Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.	Benefit level is based on the setting where each Covered Health Service is received. Examples include but are not limited to the following: Benefits for Pregnancy during an Inpatient Stay in a Hospital will be the same as found under Hospital - Inpatient Stay in this Benefit Summary. Benefits for laboratory services associated with Pregnancy will be the same as found under Lab, X-Ray and Diagnostics - Outpatient in this Benefit Summary. Benefits for pharmaceutical products for Pregnancy received on an outpatient basis will be the same as found under Pharmaceutical Products - Outpatient in this Benefit Summary.	Benefit level is based on the setting where each Covered Health Service is received. Examples include but are not limited to the following: Benefits for Pregnancy during an Inpatient Stay in a Hospital will be the same as found under Hospital - Inpatient Stay in this Benefit Summary. Benefits for laboratory services associated with Pregnancy will be the same as found under Lab, X-Ray and Diagnostics - Outpatient in this Benefit Summary. Benefits for pharmaceutical products for Pregnancy received on an outpatient basis will be the same as found under Pharmaceutical Products - Outpatient 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 and Orthotic Devices		
	100% after Deductible has been met.	70% after Deductible has been met.
Reconstructive Procedures		
	Benefit level is based on the setting where each Covered Health Service is received. Examples include but are not limited to the following: Benefits for reconstructive procedures during an Inpatient Stay in a Hospital will be the same as found under Hospital - Inpatient Stay in this Benefit Summary. Benefits for reconstructive procedures during outpatient surgery will be the same as found under Surgery - Outpatient in this Benefit Summary. Benefits for reconstructive procedures received during a Physician's office visit will be the same as found under Physician's Office Services - Sickness and Injury in this Benefit Summary.	Benefit level is based on the setting where each Covered Health Service is received. Examples include but are not limited to the following: Benefits for reconstructive procedures during an Inpatient Stay in a Hospital will be the same as found under Hospital - Inpatient Stay in this Benefit Summary. Benefits for reconstructive procedures during outpatient surgery will be the same as found under Surgery - Outpatient in this Benefit Summary. Benefits for reconstructive procedures received during a Physician's office visit will be the same as found under Physician's Office Services - Sickness and Injury in this Benefit Summary. *Prior Authorization is required.*

Types of Coverage	Network Benefits	Non-Network Benefits
Rehabilitation Services - Outpatient Therapy		
Benefits are limited as follows: 20 visits of physical therapy 20 visits of occupational therapy 20 visits of pulmonary rehabilitation 36 visits of cardiac rehabilitation 30 visits of post-cochlear implant aural therapy 20 visits of cognitive rehabilitation therapy These limits do not apply to Therapeutic Care for Treatment of Autism Spectrum Disorder.	100% after the Deductible has been met and you pay a $30 Copayment per visit.	70% after Deductible has been met.
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.	100% after Deductible has been met.	70% after Deductible has been met.
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services		
Benefits are limited as follows: 120 days per year	100% after Deductible has been met.	70% after Deductible has been met. *Prior Authorization is required.*
Surgery - Outpatient		
	100% after Deductible has been met.	70% after Deductible has 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		
	Benefit level is based on the setting where each Covered Health Service is received. Examples include but are not limited to the following: Benefits for transplantation services during an Inpatient Stay in a Hospital will be the same as found under Hospital - Inpatient Stay in this Benefit Summary. Benefits for transplantation services during a Physician's office visit will be the same as found under Physician's Office Services - Sickness and Injury in this Benefit Summary. Benefits for transplantation services during outpatient surgery will be the same as found under Surgery - Outpatient in this Benefit Summary. For Network Benefits, services must be received at a Designated Facility.	Benefit level is based on the setting where each Covered Health Service is received. Examples include but are not limited to the following: Benefits for transplantation services during an Inpatient Stay in a Hospital will be the same as found under Hospital - Inpatient Stay in this Benefit Summary. Benefits for transplantation services during a Physician's office visit will be the same as found under Physician's Office Services - Sickness and Injury in this Benefit Summary. Benefits for transplantation services during outpatient surgery will be the same as found under Surgery - Outpatient in this Benefit Summary. *Prior Authorization is required.*
Routine Vision Examination		
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 every 2 years	100% after the Deductible has been met and you pay a $30 Copayment per visit.	70% after Deductible has been met.

Types of Coverage	Network Benefits	Non-Network Benefits
Autism Spectrum Disorder Treatment		
	Benefit level is based on the setting where each Covered Health Service is received. Examples include but are not limited to the following: Benefits for Autism Spectrum Disorders Treatment during a Physician's office visit will be the same as found under Physician's Office - Sickness and Injury in this Benefit Summary. Benefits for Therapeutic Treatments for Autism Spectrum Disorders will be the same as found under Rehabilitation Services - Outpatient Therapy in this Benefit Summary. Benefits for pharmaceutical products received on an outpatient basis for Autism Spectrum Disorders Treatment will be the same as found under Pharmaceutical Products - Outpatient in this Benefit Summary.	Benefit level is based on the setting where each Covered Health Service is received. Examples include but are not limited to the following: Benefits for Autism Spectrum Disorders Treatment during a Physician's office visit will be the same as found under Physician's Office - Sickness and Injury in this Benefit Summary. Benefits for Therapeutic Treatments for Autism Spectrum Disorders will be the same as found under Rehabilitation Services - Outpatient Therapy in this Benefit Summary. Benefits for pharmaceutical products received on an outpatient basis for Autism Spectrum Disorders Treatment will be the same as found under Pharmaceutical Products - Outpatient in this Benefit Summary. *Prior Authorization is required.*
Chiropractic Services		
Coinsurance for Covered Health Services provided within the scope of a chiropractor's licenses will not exceed 50% of the total cost of any single chiropractic service as defined by Missouri law. No visit limit applies and there is no prior authorization required.	100% after Deductible has been met.	70% after Deductible has been met.
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 Benefit limits for routine care services for Clinical Trials are the same as limits for similar routine care services for any other physical Sickness.	Benefit level is based on the setting where each Covered Health Service is received. Examples include but are not limited to the following: Benefits for Clinical Trials during a Hospital - Inpatient Stay will be the same as found under Hospital - Inpatient Stay in this Benefit Summary. Benefits for an office visit associated with a Clinical Trial will be the same as found under Physician Office Visits - Sickness and Injury in this Benefit Summary. Benefits for laboratory services associated with a Clinical Trial will be the same as found under Lab, X-Ray and Diagnostics - Outpatient in this Benefit Summary. *Prior Authorization is required.*	Benefit level is based on the setting where each Covered Health Service is received. Examples include but are not limited to the following: Benefits for Clinical Trials during a Hospital - Inpatient Stay will be the same as found under Hospital - Inpatient Stay in this Benefit Summary. Benefits for an office visit associated with a Clinical Trial will be the same as found under Physician Office Visits - Sickness and Injury in this Benefit Summary. Benefits for laboratory services associated with a Clinical Trial will be the same as found under Lab, X-Ray and Diagnostics - Outpatient in this Benefit Summary. *Prior Authorization is required.*

Types of Coverage	Network Benefits	Non-Network Benefits
Dental Anesthesia and Facility Charges		
	Benefit level is based on the setting where each Covered Health Service is received. Examples include but are not limited to the following: Benefits for dental anesthesia received during an Inpatient Stay in a Hospital will be the same as found under Hospital - Inpatient Stay in this Benefit Summary. Benefits for dental anesthesia received on an outpatient basis will be the same as found under Surgery - Outpatient in this Benefit Summary. Benefits for Physician fees for dental anesthesia and facility charges will be the same as found under Physician Fees for Surgical and Medical Services in this Benefit Summary.	Benefit level is based on the setting where each Covered Health Service is received. Examples include but are not limited to the following: Benefits for dental anesthesia received during an Inpatient Stay in a Hospital will be the same as found under Hospital - Inpatient Stay in this Benefit Summary. Benefits for dental anesthesia received on an outpatient basis will be the same as found under Surgery - Outpatient in this Benefit Summary. Benefits for Physician fees for dental anesthesia and facility charges will be the same as found under Physician Fees for Surgical and Medical Services in this Benefit Summary. *Prior Authorization is required.*
Early Intervention Services		
	Benefit level is based on the setting where each Covered Health Service is received. Examples include but are not limited to the following: Benefits for early intervention services that are considered Durable Medical Equipment will be the same as found under Durable Medical Equipment in this Benefit Summary. Benefits for early intervention services during a Physician's office visit will be the same as found under Physician's Office Services - Sickness and Injury in this Benefit Summary. Benefits for early intervention services that are considered rehabilitation services will be the same as found under Rehabilitation Services - Outpatient Therapy in this Benefit Summary.	Benefit level is based on the setting where each Covered Health Service is received. Examples include but are not limited to the following: Benefits for early intervention services that are considered Durable Medical Equipment will be the same as found under Durable Medical Equipment in this Benefit Summary. Benefits for early intervention services during a Physician's office visit will be the same as found under Physician's Office Services - Sickness and Injury in this Benefit Summary. Benefits for early intervention services that are considered rehabilitation services will be the same as found under Rehabilitation Services - Outpatient Therapy in this Benefit Summary. *Prior Authorization is required.*
Enteral Formulas and Low Protein Modified Foods Products		
	100% after Deductible has been met.	70% after Deductible has been met.
Hearing Screening for Newborns		
	100% Deductible does not apply.	70% after Deductible has been met.

Types of Coverage	Network Benefits	Non-Network Benefits
Human Leukocyte Testing		
	Benefit level is based on the setting where each Covered Health Service is received. Examples include but are not limited to the following:	Benefit level is based on the setting where each Covered Health Service is received. Examples include but are not limited to the following:
	Benefits for laboratory tests related to human leukocyte testing will be the same as found under Lab, X-Ray and Diagnostics - Outpatient in this Benefit Summary.	Benefits for laboratory tests related to human leukocyte testing will be the same as found under Lab, X-Ray and Diagnostics - Outpatient in this Benefit Summary.
	Benefits for human leukocyte testing during a Physician's office visit will be the same as found under Physician's Office Services - Sickness and Injury in this Benefit Summary.	Benefits for human leukocyte testing during a Physician's office visit will be the same as found under Physician's Office Services - Sickness and Injury in this Benefit Summary.
Lead Poisoning Testing		
	Benefit level is based on the setting where each Covered Health Service is received. Examples include but are not limited to the following:	Benefit level is based on the setting where each Covered Health Service is received. Examples include but are not limited to the following:
	Benefits for lead poisoning testing during a Physician's office visit will be the same as found under Physician's Office Services - Sickness and Injury in this Benefit Summary.	Benefits for lead poisoning testing during a Physician's office visit will be the same as found under Physician's Office Services - Sickness and Injury in this Benefit Summary.
	Benefits for lead poisoning testing that are preventive in nature will be the same as found under Preventive Care Services in this Benefit Summary.	Benefits for lead poisoning testing that are preventive in nature will be the same as found under Preventive Care Services in this Benefit Summary.
	Benefits for lab, x-ray and diagnostic services related to lead poisoning will be the same as found under Lab, X-Ray and Diagnostics - Outpatient in this Benefit Summary.	Benefits for lab, x-ray and diagnostic services related to lead poisoning will be the same as found under Lab, X-Ray and Diagnostics - Outpatient in this Benefit Summary.
Mental Health Services		
	Inpatient: 100% after Deductible has been met.	Inpatient: 70% after Deductible has been met.
	Outpatient: 100% after the Deductible has been met and you pay a $30 Copayment per visit.	Outpatient: 70% after Deductible has been met. *Prior Authorization is required for certain services.*

Types of Coverage	Network Benefits	Non-Network Benefits
Osteoporosis Services		
	Benefit level is based on the setting where each Covered Health Service is received. Examples include but are not limited to the following: Benefits for osteoporosis services that are preventive in nature will be the same as found under Preventive Care Services in this Benefit Summary. Benefits for lab, x-ray and diagnostic services related to osteoporosis services will be the same as found under Lab, X-Ray and Diagnostics - Outpatient in this Benefit Summary. Benefits for osteoporosis services during a Physician's office visit will be the same as found under Physician's Office Services - Sickness and Injury in this Benefit Summary.	Benefit level is based on the setting where each Covered Health Service is received. Examples include but are not limited to the following: Benefits for osteoporosis services that are preventive in nature will be the same as found under Preventive Care Services in this Benefit Summary. Benefits for lab, x-ray and diagnostic services related to osteoporosis services will be the same as found under Lab, X-Ray and Diagnostics - Outpatient in this Benefit Summary. Benefits for osteoporosis services during a Physician's office visit will be the same as found under Physician's Office Services - Sickness and Injury in this Benefit Summary.
Speech and Hearing Services		
	Benefit level is based on the setting where each Covered Health Service is received. Examples include but are not limited to the following: Benefits for speech and hearing therapy related to rehabilitation will be the same as found under Rehabilitation Services - Outpatient Therapy in this Benefit Summary. Benefits for speech and hearing services during a Physician's office visit will be the same as found under Physician's Office Services - Sickness and Injury in this Benefit Summary. Benefits for lab, x-ray and diagnostic services related to speech and hearing testing will be the same as found under Lab, X-ray and Diagnostics - Outpatient in this Benefit Summary.	Benefit level is based on the setting where each Covered Health Service is received. Examples include but are not limited to the following: Benefits for speech and hearing therapy related to rehabilitation will be the same as found under Rehabilitation Services - Outpatient Therapy in this Benefit Summary. Benefits for speech and hearing services during a Physician's office visit will be the same as found under Physician's Office Services - Sickness and Injury in this Benefit Summary. Benefits for lab, x-ray and diagnostic services related to speech and hearing testing will be the same as found under Lab, X-ray and Diagnostics - Outpatient in this Benefit Summary.
Substance Use Disorder Services		
	Inpatient: 100% after Deductible has been met. Outpatient: 100% after the Deductible has been met and 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.*

EXCLUSIONS

It is recommended that you review your COC, Amendments and Riders for an exact description of the services and supplies that 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 chiropractic services or non-manipulative osteopathic care for which Benefits are provided as described in Section 1 of the COC.

Autism Spectrum Disorders Treatment

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, therefore, considered not Medically Necessary. Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act. Services or supplies for the diagnosis or treatment of Mental Illness that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee are determined to be considered Experimental or Investigational Services or are not Medically Necessary as defined.

Dental

Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia, except as described under Dental Anesthesia and Facility Charges in Section 1 of the COC). 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 cancer, cleft palate or diseases of the mouth and if Injury to the tooth was a serious Injury as described under Dental Services - Accident Only in Section 1 of the COC. 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 items needed for the medically appropriate treatment of newborn children diagnosed with congenital defects or birth abnormalities. Cranial banding. This exclusion does not apply to items needed for the medically appropriate treatment of newborn children diagnosed with congenital defects or birth abnormalities. 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-esophogeal voice devices for which Benefits are provided as described under Durable Medical Equipment in Section 1 of the COC. This exclusion does not apply to assistive technology devices for children from birth to age three who are eligible for services under Part C of the Individuals with Disabilities Education Act, 20 U.S.C. Section 1431. 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.

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.

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.
- 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. Educational/behavioral services that are not included in an approved treatment plan and/or considered Experimental or Investigational Services 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. Services or supplies for the diagnosis or treatment of Mental Illness that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are determined to be considered Experimental or Investigational Services or are not Medically Necessary as defined.

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 enteral formulas for Covered Persons under the age 6, for which Benefits are provided as described under Enteral Formulas and Low Protein Modified Food Products in Section 1 of the COC. 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). This exclusion does not apply to enteral formulas for Covered Persons under age 6, for which Benefits are provided as described under Enteral Formulas and Low Protein Modified Food Products in Section 1 of the COC.

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 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 an surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. Rehabilitation services 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. This does not apply to Autism Spectrum Disorders. Outpatient cognitive rehabilitation therapy when not Medically Necessary for chronic or progressive conditions such as cerebral palsy, Alzheimer's disease or Parkinson's disease. 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. 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 dislocation, tumors, cancer, obstructive sleep apnea or a Congenital Anomaly or Injury as described in the Reconstructive Procedures Benefit 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 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. Health Services and associated expenses for surgical, non-surgical or drug induces Pregnancy termination. This exclusion does not apply if the abortion procedure is necessary to preserve the life of the female upon whom the abortion is performed. Fetal reduction surgery. This exclusion does not apply if the abortion procedure is necessary to preserve the life of the female upon whom the abortion is performed.

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 not included in an approved treatment plan and/or considered not Medically Necessary or are considered as Experimental or Investigational Services focused primarily on 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 the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are determined to be considered Experimental or Investigational Services or are not Medically Necessary as defined.

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

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).

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. This exclusion does not apply if you are eligible for and choose continuation coverage or if you are eligible for extended coverage for Total Disability. For more information refer to Section 4: When Coverage Ends. 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.