EXCLUSIONS AND LIMITATIONS

The following is a list of services, supplies, etc., that are excluded under the policy unless otherwise noted.

1. All assistive communication devices.
2. Any treatment for which there is Insufficient Evidence Of Therapeutic Value for the use for which it is being prescribed is not covered.
3. Any treatment or services related to the provision of a non-covered benefit, including educational and administrative services related to the use or administration of a non-covered benefit, as well as evaluations and medical complications resulting from receiving services that are not covered ("Related Services"), unless **BOTH** of these conditions are met:
   - The Related Services are Medically Necessary acute inpatient care services needed by the Member to treat complications resulting from the non-covered benefit when such complications are life threatening at the time the Related Services are rendered, as determined by us, and
   - The Related Services would be a Health Service if non-covered benefit were covered by the Plan.
4. Attorney fees.
5. Benefits for services rendered before the Member's Effective Date under this Plan and after the Plan has been rescinded, suspended, canceled, or interrupted or terminated.
6. Blood donation expenses incurred by the Member's relatives or friends for their blood donated for use by the Member. Also, whole blood, blood plasma, and other blood derivatives and donor services, which are provided by the Red Cross and cord blood retrieval and storage.
7. Cardiac rehabilitation for Phase III, unless the Member meets the criteria for enrollment into our HeartCare health management program, is being actively case managed and the rehabilitation is approved by us. Phase III Cardiac Rehabilitation may be covered as part of a health management program value-added service or benefit. Phase IV cardiac rehabilitation is always excluded.
8. Care, treatment, services or supplies to the extent the Member has obtained benefits under any applicable law, government program, public or private grant, or for which there would be no charge to the Member in the absence of this Plan, except where benefits are obtained in a Veteran's Home or Hospital for a non service connected disability or as required by applicable law. However, care treatment or services that are otherwise Medically Necessary and provided in a Veteran's Hospital are covered.
9. Conditions with the following diagnoses:
   - Caffeine-related disorders,
   - Communication disorders,
   - Learning disorders,
   - Mental retardation,
   - Motor skills disorders,
   - Relational disorders,
   - Sexual deviation, and
   - Other conditions that may be a focus of clinical attention not defined as mental disorders in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders".
10. Cosmetic Treatments and procedures, including, but not limited to:
    - Abdominoplasty, lipectomy and panniculectomy,
    - Any medical or Hospital services related to Cosmetic Treatments or procedures,
    - Benign nevus or any benign skin lesion removal (except when the nevus or skin lesion causes significant impairment of physical or mechanical function),
    - Benign seborrhic keratosis,
    - Blepharoplasty, unless the upper eye lid obstructs the pupil, and blepharoplasty would result in significant improvement of the upper field of vision,
    - Breast augmentation, including reduction mammoplasty for Members under age 18, (except or as described in the "Reconstructive Surgery" and "Durable Medical Equipment (DME) Including Prosthetics" subsections of the "Benefits" section of this Policy or as otherwise required by applicable law),
    - Dermabrasion,
    - Excision of loose or redundant skin and/or fat after the Member has had a substantial weight loss,
    - Liposuction,
    - Otoplasty,
    - Scar revision following surgery or injury (except when the scar causes significant impairment of physical or mechanical function,
    - Septoplasty, septorhinoplasty, and rhinoplasty, unless necessary to alleviate a significant nasal obstruction,
    - Skin tag removal,
    - Spider vein removal (including sclerotherapy),
    - Tattoo removal,
    - Treatment of craniofacial disorders, except as otherwise described in the "Craniofacial Disorders" subsection of the "Benefits" section, and
    - Vascular birthmark removal (except when the vascular birthmark causes significant impairment of physical or mechanical function).
11. Custodial Care, convalescent care, domiciliary care, and rest home care. Also care provided by home health aides that is not patient care of a medical or therapeutic nature or care provided by non-licensed professionals.
12. Dental services, including but not limited to the following are excluded, except as otherwise provided in your Benefit Summary:
    - Anesthesia, except as otherwise required by State law,
    - Bite appliances or night guards,

- Bone grafts,
- Correction of congenital malformation, including genial, mandibular or maxillary osteotomies, and vestibuloplasty,
- Correction of oral malocclusion,
- Crowns,
- Dental implants,
- Prosthetic devices, except as otherwise provided herein,
- Repair, restoration or re-implantation of teeth following an injury, and
- Tooth extractions, including impacted teeth

NOTE: some Plan options cover limited dental care as described in the "Dental Care" provisions of the "Additional Services" subsection of the "Benefits" section of this Policy.

You will know dental care is part of your Plan, if your Benefit Summary includes Dental Care provisions and corresponding Cost-Share amounts.

NOT ALL PLAN OPTIONS HAVE DENTAL CARE BENEFITS.

13. Education services, including testing, training, rehabilitative for educational purposes and screening and treatment associated with learning disabilities, unless covered under the "Autism Services" subsection of the "Benefits" section.
14. Experimental Or Investigational treatment..
15. Family planning services, including but not limited to:
    - Contraceptive drugs and devices, except to the extent applicable insurance law requires coverage for these items. When they are covered, they are covered under our ***Prescription Drug Rider***. If you do not have our ***Prescription Drug Rider*** as part of this Plan, there is no coverage for contraceptive drugs and devices,
    - Home births (except that care related to complications of home births shall be covered),
    - Infertility services not specifically covered under the "Infertility Services" subsection of the "Benefits" section and our ***Prescription Drug Rider*** (if your Plan has this supplemental coverage), are excluded, including but not limited to the following:
      - All infertility services following reversal of voluntary sterilization.
      - Cryopreservation (freezing) or banking of eggs, embryos, or sperm.
      - Genetic analysis and testing, except as described in this "Genetic Testing" subsection of the "Benefits" section.
      - Medications for sexual dysfunction.
      - Recruitment, selection and screening and any other expenses of donors (donors of eggs, embryos and sperm).
      - Reversal of surgical sterilization.
      - Reversal of voluntary surgical sterilization.
      - Surrogacy and all charges associated with surrogacy.
    - Labor doulas and labor coaches.
16. Foot orthotics, except if the member is diabetic.
17. Health club membership and exercise equipment.
18. Hearing aids, except as otherwise described in the "Durable Medical Equipment (DME), Including Prosthetics" subsection of the "Benefits" section.
19. Hypnosis (except as an integral part of psychotherapy), biofeedback (except when ordered by a physician to treat urinary incontinence), acupuncture, and certain holistic practices.
20. Infant formulas, food supplements, nutritional supplements and enteral nutritional therapy, except as provided in the "Nutritional Supplements And Food Products" subsection of the "Benefits" section of this Policy or our ***Prescription Drug Rider***, if applicable.
21. Massage, except when part of a prescribed physical or occupational therapy program if that program is a covered benefit.
22. Maternity care and treatment (pre-natal and post-natal) including home births are excluded, except that care related to complications of pregnancy is covered.
23. Medical supplies or equipment that are not considered to be durable medical equipment or disposable medical supplies or that are not on our covered list of such equipment or supplies.
24. Neuropsychological and neurobehavioral testing, except when it is performed by an appropriately licensed neurologist, psychologist, or psychiatrist and when it is performed to assess the extent of any cognitive or developmental delays due to chemotherapy or radiation treatment in a child diagnosed with cancer.
25. New Treatments for which we have not yet made a coverage policy.
26. Non-durable equipment such as orthopedic or prosthetic shoes.
27. Non-Emergency land ambulance/medical transport services to and from a physician's office for routine care.
28. Non-Medically Necessary services or supplies.
29. Non-medical supportive counseling services (individual or group) for alcohol or substance abuse (e.g., Alcoholics Anonymous).
30. Overnight or day camps focused on illness or disability.
31. Over-the-counter (OTC) devices of any kind, including but not limited to home testing or other kits and products, except as provided throughout the "Benefits" section.
32. Peak flow meters are excluded.
    However, peak flow meters may be covered if:
    - The Member is enrolled in our asthma health management program,
    - Is being actively case managed, and

- The use of the peak flow meter is approved by us.

When those conditions are met, peak flow meters may be provided as part of an asthma health management program value-added service or as a benefit.

33. Personal convenience or comfort items of any kind.
34. Physical therapy, occupational therapy, speech therapy or chiropractic therapy that is long term or maintenance.
35. Private room accommodations and private duty nursing in a facility.
36. Routine foot care and treatment, unless Medically Necessary for neuro-circulatory conditions.
37. Routine physical exams and immunizations at an Urgent Care Center.
38. Sensory and auditory integration therapy, unless covered under the "Autism Services" and "Birth To Three Program (Early Intervention Services)" subsections of the "Benefits" section.
39. Services and supplies exceeding the applicable benefit maximums.
40. Services and supplies not specifically included in this Policy, except as otherwise described in one of our supplemental coverage Riders, if applicable.
41. Services or supplies rendered by a physician or provider to himself or herself, or rendered to his or her family members, such as parents, grandparents, spouse, children, step-children, grandchildren or siblings.
42. Services rendered at Hospital-based clinics are excluded unless the Hospital clinics are contracted with us for specific services.
43. Services (e.g., physical examinations, blood tests), supplies, vaccinations/immunizations and medications, including prophylactic, required by or received at a wilderness camp or a boarding school.
44. Services (e.g., physical examinations, blood tests), supplies, vaccinations/immunizations and medications, including prophylactic, required by third parties or obtained for foreign or domestic travel (e.g., employment, school, camp, licensing, insurance, travel and pursuant to a court order).
45. Sex change services.
46. Smoking cessation products are excluded, except as otherwise required by applicable law. When that occurs, the product must be obtained with a prescription and Pre-Authorized.

    In addition, we may also cover smoking cessation products if:

    - The Member is enrolled in one of our health management programs (except our maternity health management program),
    - Is being actively case managed, and
    - The use of the smoking cessation product is approved by us.

    When those conditions are met, smoking cessation products may be provided as part of a health management program value-added service or as a benefit.
47. Speech therapy for stuttering, lisp correction, or any speech impediment not related to illness or injury, except as required by applicable law.
48. Temporomandibular joint (TMJ) dysfunction or temporomandibular disease (TMD) syndrome: any non-surgical treatment, including but not limited to appliances, behavior modification, physiotherapy, and prosthodontic therapy.
49. Third party coverage, such as other primary insurance, workers' compensation and Medicare will not be duplicated.
50. Transportation, accommodation costs, and other non-medical expenses related to Health Services (whether they are recommended by a physician or not), except as otherwise described in the "Benefits" section.
51. Treatment of snoring in the absence of sleep apnea.
52. Vision services including:
    - Eyeglasses and contact lenses, , unless the contact lenses are the only mechanism available to restore visual function for a Member who has no visual function
    - Eye surgeries and procedures primarily for the purpose of correcting refractive defects of the eyes,
    - Vision and hearing examinations, except as set forth in the "Eye Care" and "Hearing Screenings" subsections of the "Benefits' section, and
    - Vision therapy and vision training.
53. War related treatment or supplies, whether the war is declared or undeclared.
54. Web visits, e-visits, and other on-line consultations, health evaluations using internet resources, as well as telephone consultations.
55. Weight loss/control treatment, programs, clinics, medications, and surgical treatment for morbid obesity.
56. Wigs, hair prosthetics, scalp hair prosthetics and cranial prosthetics, except for a wig as prescribed by an oncologist when the wig is required in connection with hair loss suffered as a result of chemotherapy or radiation therapy, as described in the "Durable Medical Supplies (DME), Including Prosthetics" subsection of the "Benefits" section.

IMPORTANT INFORMATION

Eligibility

To become eligible for benefits under this Benefit Program, the applicant must:

- Be a resident of the State of Connecticut
- Be under age 65

Renewal Provision

The Policy will automatically renew each time you send us premium payment. Payment must be made on or before the due date or by the end of the calendar month the premium is due. Your policy will remain in force during this time. We can refuse to renew your policy only when we refuse to renew all individual plans in this State. Nonrenewal will not affect an existing claim.

Premium Rates

The amount, time and manner of payment of premium shall be determined by ConnectiCare and shall be subject to the approval of the State of Connecticut Insurance Department.

In the event of any change in premium, the subscriber will be given notice at least 30 days prior to such change. Payment of the premium by the subscriber shall serve as notice of the subscriber's acceptance of the change.

If you have questions regarding this plan, please contact your insurance agent or call us at **(860) 674-5757** or **1-800-251-7722**.