

BlueChoice HSA DC: EXCLUSIONS/LIMITATIONS

Coverage is not provided for:

1. Services, tests or procedures that are not Medically Necessary. Although a service is listed as covered, benefits will be provided only if the service is Medically Necessary.
2. Experimental or Investigative: treatment; procedure; facility; equipment; drug; drug usage; device or supply.

3. The cost of services that:
 - a. Are furnished without charge; or,

 - b. Are normally be furnished without charge to persons without coverage for health expenses.

4. This exclusion does not apply to services that are covered under a Medical Assistance Program.

5. Medical services to the extent that they are payable under the personal injury protection (PIP) provisions of the Member's motor vehicle casualty insurance on the date that a claim is submitted for PIP benefits.

6. Covered under PIP is insurance coverage without regard to fault provided under a Member's motor vehicle casualty insurance. The Plan is not liable for these medical services.
 - a. Services that are not described as covered in this Certificate or that do not meet all other conditions and criteria for coverage, as determined by the Plan. Referral by a Primary Care Physician and/or the provision of services by a Plan Provider does not, by itself, entitle a Member to benefits if the services are non-covered services or do not otherwise meet the conditions and criteria for coverage.

 - b. Any routine foot care related to hygiene or preventive foot care such as: trimming of corns; calluses; flat feet; fallen arches; chronic foot strain; or, partial removal of a nail without the removal of its matrix.

 - c. Routine dental care such as extractions; treatment of cavities; care of the gums or bones supporting the teeth; treatment of periodontal abscess; removal of impacted teeth; orthodontia; false teeth; or, any other dental services or supplies. These services may be covered under a Dental Rider purchased by the Subscriber and attached to this Certificate. This exclusion will not be used to deny covered services for orthodontia as described in Section 7.14 for cleft lip - cleft palate, or both, or reconstructive surgery for accidental injuries as described in Section 7.15.

 - d. Plastic surgery, cosmetic surgery or other services primarily intended to correct, change or improve appearance. Such services are excluded, regardless of the underlying cause of the condition or any expectation that an alteration of appearance may be psychologically or developmentally beneficial. This exclusion will not be used to deny covered services for reconstructive surgery described in Section 7.15.

7. Treatment rendered by a health care provider who is a member of the Member's family (parents, spouse, brothers, sisters, children).
 - a. Prescription and non-prescription drugs routinely obtained and self-administered by the Member for outpatient use; unless the prescription drug is specifically covered under this Certificate or a Prescription Drug Rider when such Rider is attached to this Certificate.

- b. Artificial aids and corrective appliances, such as: braces; external prosthetic devices; orthopedic devices; hearing aids; corrective lenses; or, eyeglasses.
- c. Any procedure or treatment related to changing a Member's sex.
- d. Services to reverse voluntary surgically induced infertility, such as a reversal of a sterilization.
- e. Infertility treatment including but not limited to: assisted reproductive technologies such as: in vitro fertilization; GIFT; ZIFT; related evaluative procedures; artificial insemination; and, any drugs, diagnostic services or medical preparation related to the same.
- f. Fees or charges relating to: fitness programs; weight loss or weight control programs; physical, pulmonary or cardiac conditioning programs; exercise programs; physical conditioning; use of passive or patient-activated exercise equipment; or, self-care or self-help training or education, except as covered under Section 7.10.
- g. Treatment for obesity except in the instance of morbid obesity.
- h. Wigs, except for a hair prosthesis as described in Part 7.2.r.
- i. Medical or surgical treatment of myopia or hyperopia. Coverage is not provided for radial keratotomy and other forms of refractive keratoplasty or any complications thereof.
- j. Services furnished as a result of a referral prohibited by law.
- k. Services solely required or sought on the basis of a court order or as a condition of parole or probation unless approved by the Medical Director.
- l. Chiropractic services.

- m. Health education classes and self-help programs, except as approved by the Plan.
- n. Acupuncture services except for anesthesia.
- o. Any service related to recreational activities. This includes, but is not limited to: sports; games; equestrian activities; and, athletic training. These services are not covered even though: they may have therapeutic value; or, be provided by a health care provider.

BlueChoice-Saver DC: EXCLUSIONS/LIMITATIONS

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2. Experimental or Investigative: treatment; procedure; facility; equipment; drug; drug usage; device or supply.
3. This exclusion does not apply to services that are covered under a State Assistance Program. The cost of services that
 - a. Are furnished without charge; or,
 - b. Are normally furnished without charge to persons without coverage for health expenses.
4. Medical services to the extent that they are payable under the personal injury protection (PIP) provisions of the Member's motor vehicle casualty insurance on the date that a claim is submitted for PIP benefits. Covered under PIP is insurance coverage without regard to fault provided under a Member's motor vehicle casualty insurance. The Plan is not liable for these medical services
5. Services that are not described as covered in this Certificate or that do not meet all other conditions and criteria for coverage, as determined by the Plan. Referral by a Primary Care Physician and/or the provision of services by a Plan Provider does not, by itself, entitle a Member to benefits if the services are non-covered services or do not otherwise meet the conditions and criteria for coverage.
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7. Routine dental care such as extractions; treatment of cavities; care of the gums or bones supporting the teeth; treatment of periodontal abscess; removal of impacted teeth; orthodontia; false teeth; or, any other dental services or supplies. These services may be covered under a Dental Rider purchased by the Subscriber and attached to this Certificate. This exclusion will not be used to deny covered services for orthodontia as described in the Certificate for cleft lip - cleft palate, or both, or reconstructive surgery for accidental injuries as described in the Certificate.
8. Plastic surgery, cosmetic surgery or other services primarily intended to correct, change or improve appearance. Such services are excluded, regardless of the underlying cause of the condition or any expectation that an alteration of appearance may be psychologically or developmentally beneficial. This exclusion will not be used to deny covered services for reconstructive surgery as described in the Certificate.
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