

## BluePreferred HSA DC: EXCLUSIONS/LIMITATIONS

1. **Medical Necessity and Appropriateness.** Benefits will not be provided for services, tests, procedures or supplies which we determine are not necessary for the prevention, diagnosis or treatment of the Member's illness, injury or condition. Although a service or supply is listed as covered, benefits will be provided only if it is medically necessary and appropriate in the Member's particular case. A service or supply is medically necessary and appropriate only if, in our judgment it is:
  - a. Necessary and appropriate for the symptom, diagnosis, prevention or treatment of the Member's illness, injury or condition;
  - b. Consistent with the symptom, diagnosis, prevention or treatment of the Member's illness, injury or condition;
  - c. The most appropriate supply, treatment or level of service that can be provided safely to the Member and, if the Member is an inpatient, cannot be provided safely on an outpatient basis; and
  - d. Not primarily for the convenience of the Member or provider.

Services, supplies, and accommodations will not automatically be considered Medically Necessary because they were prescribed by an Eligible Provider. We may consult with professional medical consultants, peer review committees, or other appropriate sources for recommendations on

whether the services, supplies, or accommodations a Member receives are Medically Necessary.

2. **Accepted Medical Practice.** Benefits will not be provided for any treatment, procedure, facility, equipment, drug, drug usage, device or supply which, in our judgment, is experimental, investigational or not in accordance with accepted medical or psychiatric practices and standards in effect at the time of treatment. A service or supply is deemed to be experimental or investigational if:
  - a. A preponderance of scientific data, such as controlled studies in peer-reviewed journals or literature has not demonstrated that its use results in an improved net health outcome for a specific diagnosis;
  - b. It is not in accordance with generally accepted standards of medical practice; or
  - c. It does not have federal or other required governmental agency approval at the time it is received.
3. **Free Care.** Payment will not be made for services which, if the Member were not covered under the Group Contract, would have been provided without charge, including any charge or any portion of a charge which, by law, the provider is not permitted to bill or collect from the patient directly.
4. **Routine Care of Feet.** Benefits will not be provided for any services in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, symptomatic complaints of the feet or partial removal of a nail without the removal of its matrix. However, benefits will be provided for these services if we determine that medical attention was needed because of a medical condition affecting the feet, such as diabetes and, that all other conditions for coverage have been met.
5. **Dental Care.** Except as provided in Section 0, benefits will not be provided for any other type of dental care including 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, unless provided in a separate Rider or Endorsement to this Agreement.
6. **Oral Surgery.** Benefits are limited to non-dental surgical procedures for congenital defects, such as hare lip or cleft palate and for medically necessary diagnostic and surgical procedures occurring within or adjacent to the oral cavity or sinuses including, but not limited to procedures to correct accidental injuries of the jaw, cheeks, lips, tongue, roof and floor of the mouth when such injuries occurred while covered under this Agreement; the reduction of, dislocation of, or excision of temporomandibular joints; procedures involving accessory sinuses, salivary glands or ducts; excision of tumors and cysts of the jaw, cheeks, roof and floor of the mouth when pathological examination is required; excision of exostosis of the jaw and hard palate when not related to the fitting of dentures; extraoral incision and drainage of abscesses with cellulitis. All other procedures involving the teeth or areas surrounding the teeth, including shortening of the mandible or maxillae for cosmetic purposes or for correction of malocclusion, Temporomandibular Joint Syndrome (TMJ) treatment or treatment for craniomandibular pain syndrome (CPS), will not be covered. However, benefits will be provided for surgical services for TMJ and CPS, if Medically Necessary and if there is a clearly demonstrable radiographic evidence of joint abnormality due to an illness.
7. **Cosmetic Services.** Benefits will not be provided for plastic surgery, cosmetic surgery or other services primarily intended to correct, change or improve the Member's appearance. Except as provided in paragraph (b) below, such services are excluded, regardless of the underlying cause of the condition or any expectation that an alteration of the patient's appearance may be psychologically or developmentally beneficial to the patient. Benefits for reconstructive surgery are limited to surgical procedures which, in our judgment, are
  - a. Medically necessary to correct conditions which have resulted in a functional physiological

defect;

- b. Required to correct a congenital anomaly (must be a physical defect that was apparent at birth) that has produced a major physical effect on the Member's condition and provided the surgery or procedure can be reasonably expected to correct the condition; or
  - c. Required to correct conditions which have resulted from accidental injury or non-cosmetic surgery if:
    1. The accident or surgery has produced a major physical effect on the Member's appearance; and
    2. At the time of the accident or surgery, the Member was enrolled under this coverage or another Plan-issued contract; and
    3. In our judgment, the surgery can be reasonably expected to correct the condition.
8. **Prescription Drugs.** Except as provided in a separate rider or endorsement to this Agreement, benefits will not be provided for prescription drugs, unless administered to the Member in the course of covered outpatient or inpatient treatment. Take-home prescriptions or medications, including self-administered injections which can be administered by the patient or by an average individual who does not have medical training, or medications which do not medically require administration by or under the direction of a physician are not covered, except as may be provided in a separate rider or endorsement to this Agreement, even though they may be dispensed or administered in a physician or provider office or facility.
9. **Organ Transplants.** Organ transplant procedures, including complications resulting from any such procedure, services or supplies related to any such procedure such as, but not limited to, high dose chemotherapy, radiation therapy or any other form of therapy, or immunosuppressive drugs are not covered, except as provided in Sections 0 and 0.
10. **Other Exclusions.** Benefits will not be provided for the following
- a. Services or supplies received before the effective date of your coverage under this Agreement.
  - b. Treatment of sexual dysfunctions or inadequacies limited to surgical implants for impotence (medical therapy and psychiatric treatment are not covered).
  - c. Any procedure or treatment designed to alter an individual's physical characteristics to those of the opposite sex.
  - d. Weight reduction or obesity treatment.
  - e. Speech therapy, occupational therapy or physical therapy, unless we determine that your condition is subject to improvement. Coverage does not include nonmedical ancillary services such as vocational rehabilitation, employment counseling, or educational therapy.
  - f. Fees and charges relating to fitness programs, weight loss or weight control programs, physical, pulmonary conditioning programs or other programs involving such aspects as exercise, physical conditioning, use of passive or patient-activated exercise equipment or facilities and self-care or self-help training or education. Cardiac rehabilitation programs are covered as described in Section 0.
  - g. Medical or surgical treatment of myopia or hyperopia, including radial keratotomy and other forms of refractive keratoplasty or any complications thereof.
  - h. Services to the extent they are covered by any governmental unit, except in Veteran's Administration or armed forces facilities for services received, such as for non-service connected disabilities, for which the recipient is liable. Services or supplies for injuries or

diseases related to a covered person's job to the extent the covered person is required to be covered by a workers' compensation law. Services or supplies resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy, excluding no fault insurance.

- i. Services that are beyond the scope of the license of the provider performing the service.
  - j. Except for covered ambulance services, travel, whether or not recommended by an Eligible Provider.
  - k. Services or supplies for conditions that State or local laws, regulation, ordinances, or similar provisions require to be provided in a public institution.
  - l. Services or supplies received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar persons or groups.
  - m. Contraceptive devices.
  - n. Partial removal of a nail without the removal of the matrix.
  - o. Assistive reproductive procedures, other than those described in Section 3.3.b.
  - p. Any claim, bill or other demand or request for payment for health care services determined to be furnished as a result of a referral prohibited by Section I-302 of the Maryland Health Occupations Article.
  - q. Services solely on court order or as a condition of parole or probation unless approved by the Plan.
  - r. Any illness or injury caused by war, declared or undeclared, including armed aggression.
- s. Any service, supply or procedure which is not specifically listed in your Agreement as a covered benefit.

#### **BluePreferred-Saver DC: EXCLUSIONS/LIMITATIONS**

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  - a. Necessary and appropriate for the symptom, diagnosis, prevention or treatment of your illness, injury or condition;
  - b. Consistent with the symptom, diagnosis, prevention or treatment of your illness, injury or condition;
  - c. The most appropriate supply, treatment or level of service that can be provided safely to the Member and, if the Member is an inpatient, cannot be provided safely on an outpatient basis; and
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