

## EXCLUSIONS – Summary

1. Medically Unnecessary Care.
2. Care by Nonparticipating Providers.
3. Care Provided Outside of the HMO Service Area (With the exception of emergency care and urgent care)
4. Government Hospital.
5. Workers' Compensation.
6. Free Care; Care Provided by Family Members.
7. Government Programs.
8. Custodial Care.
9. Unauthorized Services. (PCP referral required except OB/GYN and Emergency Services)
10. Cosmetic Surgery.
11. Admission to a Hospital Before You Become Covered Under This Contract.
12. No-Fault Automobile Insurance.
13. Dental Care.
14. Eyeglasses and Hearing Aids.
15. Correction of Structural Imbalance, Distortion or Subluxation.
16. Routine Care of Feet.
- 17 a. Outpatient treatment of, or inpatient rehabilitation services for, alcoholism and substance abuse.
- 17.b. Examinations required by a third party, such as your employer, school or camp.
17. c. Services required for a condition arising out of: participation in a felony; suicide; attempted suicide; intentionally self-inflicted injury; or war or act of war
17. d. Sex changes.
17. e. Reversal of sterilization.
17. f. assisted reproductive technology
17. g. Nutritional counseling, except when provided in connection with diabetes education.
18. Speech, Occupational, Hearing or Vision Therapies.
19. Benefits for Disabled Medicare Eligibles Who Are Covered Under This Contract.
20. Treatments, Procedures, Hospitalization, Drugs, Biological Products or Medical Devices Which Are Experimental or Investigational.
21. Donor Fees; Transportation.
22. Charges for Services Pursuant to a Prohibited Referral (physician owned ancillary services).
23. Pre-Existing Conditions. (12 month exclusion, 6 month look back period, 63 day gap or we will apply credit for prior coverage whether it was group or individual coverage)

## EXCLUSIONS - Details

In addition to certain exclusions and limitations already described in this Contract, we will not pay under this Contract when any of the following apply to you:

- 1. Medically Unnecessary Care.** We will not pay for any treatment, service or supply that we determine is not medically necessary.
- 2. Care by Nonparticipating Providers.** Except in an emergency, we will not pay for care rendered by nonparticipating providers.
- 3. Care Provided Outside of the HMO Service Area.** With the exception of emergency care and urgent care covered under Section Seven, we will not pay for services provided to you when you are visiting, traveling or temporarily residing, outside of the 27 county HMO Service Area.
- 4. Government Hospital.** We will not pay for care in any hospital or other institution which is owned, operated or maintained by the federal government, a state government, or any local government, unless the hospital is a participating hospital. However, this exclusion does not apply to United States Veterans Administration or Department of Defense hospitals, except for services in connection with a service-related disability. In addition, we will pay for care covered under this Contract in such a hospital if, because of serious injury or sudden illness, you are taken to one of these hospitals for emergency care because it is close to the place where you were injured or became ill. In this type of emergency situation, we will continue to make payments only for as long as emergency care, in our sole judgment, is necessary and it is not possible for you to be transferred to another hospital.
- 5. Workers' Compensation.** We will not pay for any care for any injury, condition or disease if payment is available to you under a Workers' Compensation Law or similar legislation. We will not make any payments even if you do not claim the benefits you are entitled to receive under the Workers' Compensation Law. Also, we will not make any payments even if after any of the above benefits are paid, you repay them because you recover that money in a related lawsuit or other proceeding.
- 6. Free Care; Care Provided by Family Members.** We will not pay for any care if the care is furnished to you without charge or would normally be furnished to you without charge if you were not covered under this Contract or under any other insurance. This also applies even if the charges are billed. We will not pay for services rendered by a member of your immediate family.
- 7. Government Programs.** We will not pay for any service which is covered, and payment is therefore available to you, under any federal, state or local government program, except that we will pay even though you are eligible for Medicaid.
- 8. Custodial Care.** We will not pay for hospital care, nursing home or skilled nursing facility care, home care or any other service which is custodial care.
- 9. Unauthorized Services.** Except for obstetrical and gynecological services described in Section Four, Paragraph 3.G. and emergency care described in Section Seven, we will not provide benefits for any service or care unless treatment is performed, or prescribed, arranged or authorized in advance, by your PCP and, when required, approved in advance by us.
- 10. Cosmetic Surgery.** No benefits are provided for any services in connection with elective cosmetic surgery or any hospitalization in connection with such surgery. However, benefits are available for reconstructive surgery if it is incidental to or follows surgery resulting from trauma, an infection or other diseases of the involved part. With respect to a covered child, benefits are

available for reconstructive surgery to treat a functional defect resulting from a disease or anomaly that is present from birth.

**11. Admission to a Hospital Before You Become Covered Under This Contract.** If you are admitted to a hospital or skilled nursing facility as a registered bed patient before the date you become covered under this Contract, we will not pay for any part of your stay in that hospital or skilled nursing facility or for medical services related to that stay, to the extent that you have coverage under any other contract or policy of insurance, including provisions for benefits after termination in the event of disability. In addition, we will not pay for any part of the stay if your care is not transferred to and authorized by your PCP.

**12. No-Fault Automobile Insurance.** We will not pay for any service which is covered by mandatory automobile no-fault benefits. We will not make any payments even if you do not claim the benefits you are entitled to receive under the no-fault automobile insurance. Also, we will not make any payments even if after any of the above benefits are paid, you repay them because you recover that money in a related lawsuit or other proceeding.

**13. Dental Care.** We will not pay for dental surgery or anesthesia, or dental treatment of any kind including: treatment of cavities and extractions; care of the gums or bones supporting the teeth; treatment of periodontal abscess; removal of impacted teeth; orthodontia; false teeth; treatment of dental temporomandibular joint syndrome; or any other dental services you may receive. We will, however, pay for any service we cover under this Contract in connection with an accidental injury to sound natural teeth if the service is performed within 12 months of the accident.

**14. Eyeglasses and Hearing Aids.** We will not pay for eyeglasses, contact lenses, hearing aids or artificial aids, or for examination and fitting thereof.

**15. Correction of Structural Imbalance, Distortion or Subluxation.** We will not pay for any services in connection with the detection and correction (by manual or mechanical means, including X-rays) of:

- Structural imbalance; or
- Distortion; or
- Subluxation; of or related to the spine.

**16. Routine Care of Feet.** We will not pay for any services in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet.

- Reversal of sterilization.
- In-vitro fertilization, artificial insemination or other forms of assisted reproductive technology unless otherwise required by law.
- Nutritional counseling, except when provided in connection with diabetes education.

**17. We will not pay for any service, treatment or procedure in connection with any of the following:**

- Outpatient treatment of, or inpatient rehabilitation services for, alcoholism and substance abuse.
- Examinations required by a third party, such as your employer, school or camp.
- Required for a condition arising out of: participation in a felony; suicide; attempted suicide; intentionally self-inflicted injury; or war or act of war, whether declared or undeclared. However, we will pay for covered mental healthcare in connection with attempted suicide.
- Surgery, or related care such as hospital care, to alter your sex from one gender to another.
- Reversal of sterilization.
- In-vitro fertilization, artificial insemination or other forms of assisted reproductive technology unless otherwise required by law.
- Nutritional counseling, except when provided in connection with diabetes education.

**18. Therapies.** We will not pay for speech, occupational, hearing or vision therapy except as part of a covered home care visit under Section Four, Paragraph 4.B.

**19. Benefits for Disabled Medicare Eligibles Who Are Covered Under This Contract.** If you are Medicare eligible because of disability, you will continue to receive the benefits of the Contract. We will file the appropriate forms with Medicare so that the Medicare benefits will be applied to defray the premium cost of the HMO program. You must sign any claim forms or other documents which are necessary for us to obtain payments from Medicare for services provided to you through the HMO. If you do not sign the forms or other documents and submit them to us, we have the right to deny HMO payments for the service.

**20. Treatments, Procedures, Hospitalization, Drugs, Biological Products or Medical Devices Which Are Experimental or Investigational.**

We will not cover any treatment, procedure, drug, biological product or medical device (hereinafter "technology") or any hospitalization in connection with such technology if, in our sole discretion, it is not medically necessary in that such technology is experimental or investigational. Experimental or investigational means that the technology is:

- A. not of proven benefit for the particular diagnosis or treatment of your particular condition; or
- B. not generally recognized by the medical community as reflected in the published peer-reviewed medical literature as effective or appropriate for the particular diagnosis or treatment of your particular condition.

We will also not cover any technology or any hospitalization in connection with such technology if, in our sole discretion, such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of your particular condition. Governmental approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of your particular condition. We may apply the following five criteria in exercising our discretion and may in our discretion require that any or all of the criteria be met:

- Any medical device, drug or biological product must have received final approval to market by the United States Food and Drug Administration for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition may require that any or all of the five criteria be met.
- Conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale.
- Demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects.
- Proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable.
- Proof as reflected in the published peer-reviewed medical literature must exist that improvement in health outcomes, as defined above, is possible in standard conditions of medical practice, outside clinical investigatory settings.

**21. Donor Fees; Transportation.** We will not pay for donor fees and transportation costs in connection with nonexperimental organ transplants.

**22. Charges for Services Pursuant to a Prohibited Referral.** We will not pay for clinical laboratory services, or X-ray or imaging services furnished by any provider pursuant to a referral prohibited by Section 238-a of the New York State Public Health Law. Generally, Section 238-a prohibits physicians and other healthcare practitioners from making referrals for clinical laboratory services or X-ray and imaging services to a provider or facility in which the referring physician or practitioner or an immediate family member has a financial interest or relationship.

**23. Pre-Existing Conditions.** We will not pay for any pre-existing conditions until you have been enrolled under this Contract for at least 12 consecutive months. A pre-existing condition is a physical or mental condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the six month period ending on your enrollment date under this Contract. For purposes of this section, "enrollment date" means the first day of your coverage under this Contract or, if earlier, the first day of any waiting period that must pass before you are eligible to be covered for benefits under this Contract. Any period after you file a substantially complete application for coverage and before the first day of coverage is a waiting period.

Genetic information will not be treated as a pre-existing condition unless you have been diagnosed with a condition related to such information. This exclusion for pre-existing conditions does not apply:

A. If, on the last day of the 30 day period beginning on the date of birth, you are covered under Creditable Coverage as defined below.

B. To a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30 day period beginning on the date of the adoption

**Credit Towards Waiting Period.** The time you were covered under any other health insurance or HMO contract or policy or employer provided health benefit arrangement providing substantially similar benefits to those provided by this Contract before you became covered under this Contract will be counted towards the waiting period if there was no break in coverage greater than 60 days between the termination of the other coverage and the effective date of your coverage under this Contract. If the benefits of the previous coverage are not substantially similar, credit will be provided to the extent of the previous coverage. For purposes of determining whether the waiting period has been satisfied prior to February 1, 1996 or within 30 days after your coverage under a direct payment HMO contract has been discontinued, benefits under a direct payment HMO contract issued prior to January 1, 1996 shall be deemed similar to the benefits provided under this Contract. In the event you had previous HMO coverage, any general waiting period imposed by the HMO before the HMO's coverage became effective shall be counted as time you were covered for purposes of providing credit for previous coverage.

**When This Contract Is Your Conversion Contract.** The limitation on payment for pre-existing conditions described above in this paragraph will not apply when the contract from which you are converting does not have such a limitation. However, the benefits of this Contract will be reduced by any benefits paid under the contract from which you converted after termination of your coverage under such contract.