

# Mental Health and Substance Abuse Services

## Covered Services are as follows:

### Mental Illnesses and Chemical Dependency Benefits

- Inpatient treatment subject to the Hospital Inpatient Deductible, plus 50% Copayment and/or Coinsurance as listed in the Schedule of Benefits.
  - Limited to thirty (30) days per Calendar Year.
- Outpatient treatment is subject to Outpatient Deductible, plus 50% Copayment and/or Coinsurance as listed in the Schedule of Benefits.
  - Limited to thirty (30) visits per Calendar Year.

### Severe Mental Illness Benefits

- Inpatient treatment subject to the Hospital Inpatient Deductible, Copayment and/or Coinsurance as listed in the Schedule of Benefits.
- Outpatient treatment subject to applicable Deductible, Copayment and/or Coinsurance for services provided by Specialists as listed in the Schedule of Benefits.

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## CoventryOne Exclusions included in the Policy

### Unless otherwise stated in this Policy, the following items are excluded from Coverage:

1. Maternity Services – Expenses incurred for any condition of or related to pregnancy, except for complications of pregnancy. Also excluded are expenses associated with selective reduction during pregnancy.
2. Illness, treatment or medical condition arising out of war or act of war (whether declared or undeclared), while serving in the military or an auxiliary unit attached to the military in an area of war whether voluntarily or as required by an employer.
3. Cosmetic Services and Surgery – Those services, associated expenses, or complications resulting from Cosmetic Surgery, which alters appearance but does not restore or improve impaired physical function. Removal or replacement of a breast implant that was initially performed for cosmetic or augmentation purposes.
4. Foot Care – Foot care in connection with corns, calluses, flat feet, fallen arches or chronic foot strain. Medical or surgical treatment of onychomycosis (nail fungus) is also excluded, except as specifically provided for a diabetic Insured;
5. No legal obligation to pay – Services are excluded for Injuries and Illnesses for which the Plan has no legal obligation to pay (e.g., free clinics, free government programs, court-ordered care, expenses for which a voluntary contribution is requested) or for that portion of any charge which would not be made but for the availability of benefits from the Plan, or for work-related injuries and Illness. Health services and supplies furnished under or as part of a study, grant, or research program;
6. Military Health Services – Those services for treatment of military service-related disabilities when the Insured is legally entitled to other Coverage and for which facilities are reasonably available to the Insured; or those services for any otherwise Eligible Employee or Dependent who is on active military duty except as required by the Uniformed Services Employment and Reemployment Rights Act;
7. Dental Services – Those dental services provided by a Doctor of Dental Surgery, “D.D.S.,” a Doctor of Medical Dentistry “D.M.D.” or a Physician licensed to perform dental-related oral surgical procedures, including services for overbite or underbite, services related to surgery for cutting through the lower or upper jaw bone, and services for the surgical treatment of temporomandibular joint disorder (“TMJ”), whether the services are considered to be medical or dental in nature except as provided in the “Covered Services” Section of this Policy. Dental x-rays, supplies and appliances (including occlusal splints and orthodontia). The diagnosis and treatment for TMJ and craniomandibular joint disease is not Covered unless by an attached Rider. Removal of dentiginous cysts, mandibular tori and odontoid cysts are excluded as they are dental in origin;

- i. Also excluded from coverage are dental services when such services are directly related to an accidental injury. This includes but is not limited to treatment of natural teeth and the purchase, repair or replacement of dental prostheses needed as a direct result of an accidental injury.
  - ii. Removal of teeth, including any prophylactic extractions, as a complication of radionecrosis is not a Covered Service
- 8. Dental Surgery and Implants – Upper and lower jaw bone surgery and dental implants (including that related to the temporomandibular and craniomandibular joint). Dental implants are excluded;
- 9. Eye Glasses and Contact Lenses – Those charges incurred in connection with the provision or fitting of eye glasses or contact lenses, except as specifically provided in the Covered Services Section;
- 10. Custodial Care, domiciliary care, private duty nursing, respite care or rest care. This includes care that assists the Insured in the Activities of Daily Living like walking, getting in and out of bed, bathing, dressing, feeding and using the toilet; preparation of special diets and supervision of medication that is usually self-administered regardless of who orders the services;
- 11. Routine Physical Examinations – Those physical, psychiatric or psychological examinations or testing, vaccinations, immunizations or treatments when such services are for purposes of obtaining, maintaining or otherwise relating to career, camp, sports, education, travel, employment, insurance, marriage or adoption. Also excluded are routine immunizations for college, and services relating to judicial or administrative proceedings or orders, which are conducted for purposes of medical research or to obtain or maintain a license of any type;
- 12. Occupational Injury – Those services and associated expenses related to the treatment of an occupational Injury or Illness for which the Insured is eligible to receive treatment under any Workers' Compensation or occupational disease laws or benefit plans whether or not you file a claim. If you enter into a settlement giving up your right to recover future medical benefits under a Workers' Compensation policy, medical benefits that would have been paid except for the settlement will not be Covered services under this Policy.

## CoventryOne Policy Exclusions Rider

### Specifically excluded services include the following:

- 1. **Acupuncture** – Acupuncture services and associated expenses that include, but are not limited to, the treatment of certain painful conditions or for anesthesia purposes;
- 2. **Allergy Services** – Those non-Physician allergy services or associated expenses relating to an allergic condition including, but not limited to, installation of air filters, air purifiers, or air ventilation system cleaning;
- 3. **Alternative Therapies** – Those alternative therapies and associated expenses including, but not limited to, aquatic, recreational, wilderness, educational, music or sleep therapies and any related diagnostic testing; hypnotherapy and hypnosis; or massage therapy;
- 4. **Autopsy** – Those services and associated expenses related to the performance of autopsies, or post-mortem genetic studies;
- 5. **Communication and Hearing Services and Supplies** – Augmentative communication devices, including but not limited to, those used to assist hearing impaired, or physically or developmentally disabled; services and associated expenses for prescribing and fitting hearing aids, cochlear implants, digital and programmable hearing devices, hearing therapy and any related diagnostic hearing tests; speech therapy or voice training when prescribed for stuttering or hoarseness;
- 6. **Behavior Modification** – Those services and associated expenses related to behavior modification, including but not limited to biofeedback;
- 7. **Blood and Blood Products** – The cost of whole blood and blood products replacement to a blood bank; expenses related to personal blood storage, unless associated with a scheduled surgery; additionally, fetal cord blood harvesting and storage is not a Covered service;
- 8. **Counseling Services** – Expenses incurred related to religious counseling, marital/relationship counseling, vocational or employment counseling, and sex therapy are not Covered Services;
- 9. **Developmental Delay and Educational Services** – Medical services and expenses incurred for learning disabilities, developmental delays, mental retardation and autistic disorders; educational services for remedial education including, but not limited to, evaluation or treatment of learning disabilities, minimal brain dysfunction, cerebral palsy, mental retardation, learning disorders and behavioral training; Educational testing or psychological testing, unless part of a treatment program for Covered Services;
- 10. **Durable Medical Equipment (“DME”)** – Electronically controlled cooling compression therapy devices (such as polar ice packs, Ice Man Cool Therapy, or Cryo-cuff); home blood pressure monitoring devices; home traction units; replacement for changes due to obesity; preventive or routine maintenance due to normal wear and tear or negligence of items owned by the Insured; personal comfort items, including breast pumps, air conditioners, humidifiers and dehumidifiers, even though prescribed by a Physician, unless defined as Covered Services;
- 11. **Elective or Voluntary Enhancement** – Elective or voluntary enhancement procedures, services, and medications (growth hormone and testosterone), including, but not limited to: weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging, mental performance, salabrasion, chemosurgery, laser surgery or other skin abrasion procedures associated with the removal of scars, tattoos, or actinic changes. In addition, service performed for the treatment of acne scarring, even when the medical or surgical treatment has been provided by the Policy;

12. **Enteral Feeding Food Supplements** – The cost of outpatient enteral tube feedings or formula and supplies is not Covered, except as defined as a Covered Service; Food or food supplements; Nutritional-based therapies except for treatment of nutritional deficiencies due to short bowel syndrome and HIV. Oral supplements and/or enteral feedings, either by mouth or by tube, are also excluded;
13. **Growth Hormone** – Growth hormone therapy for any condition;
14. **Hair Analysis, Wigs and Hair Transplants** – Those services related to the analysis of hair unless used as a diagnostic tool to determine poisoning. Also excluded are hairstyling, hairpieces and hair prostheses, including those ordered by a Provider;
15. **Immunizations** for travel, employment or education unless otherwise Covered under the Covered Services Section, including, but not limited to, anthrax and Lyme disease vaccines;
16. **Infertility Services** – All diagnostic studies, non-diagnostic services, and certain surgical procedures that are related to diagnosing and/or treating Infertility. Also excluded are expenses incurred for the promotion of conception including, but not limited to, artificial insemination, intracytoplasmic sperm injection (“ICSI”), in vitro or in vivo fertilization, gamete intrafallopian transfer (“GIFT”) procedures, zygote intrafallopian transfer (“ZIFT”) procedures, embryo transport, egg harvesting (collection, storage, preparation), reversal of voluntary sterilization, surrogate parenting, selective reduction, cryo preservation, travel costs, donor eggs or semen and related costs including collection, preparation and storage, non-Medically Necessary amniocentesis (for example, determining sex), other forms of assisted reproductive technology and any Infertility treatment deemed Experimental or Investigational. Additionally, pharmaceutical agents used for the purpose of treating Infertility are not Covered under the terms of the Policy;
17. **Maintenance Therapy** – Once the maximum therapeutic benefit has been achieved for a given condition, ongoing Maintenance Therapy is not considered Medically Necessary;
18. **Male Gynecomastia** – Those services and associated expenses for treatment of male gynecomastia.
19. **Medical Complications** arising directly or indirectly from a non-Covered Service;
20. **Miscellaneous Service Charges** – Telephone consultations, charges for failure to keep a scheduled appointment (unless the scheduled appointment was for a Mental Health service), any late payment charge, or other non-medical charges; devices used specifically as safety items or to affect performance primarily in sports-related activities;
21. **Non-Prescription Drugs and Medications** – Over-the-counter (“OTC”) drugs and medications incidental to outpatient care and Urgent Care Services are excluded unless specifically stated as Covered in the Covered Services Section of this Policy or as specifically provided in an optional pharmacy Rider;
22. **Obesity Services** – Those services and associated expenses for procedures intended primarily for the treatment of obesity and morbid obesity including, but not limited to, gastric bypasses, gastric balloons, stomach stapling, jejunal bypasses, wiring of the jaw, removal of excess skin, including pannus, and services of a similar nature. Services and associated expenses for weight loss programs, nutritional supplements, dietary counseling, appetite suppressants, and supplies of a similar nature;
23. **Orthotic Appliances, Prosthetic Devices, Repairs or Replacement** – The replacement costs for any otherwise Covered device including, but not limited to, changes due to obesity; routine maintenance due to normal wear and tear or negligence of items owned by the Insured; Also excluded are foot or shoe inserts, arch supports, special orthopedic shoes, heel lifts, heel or sole wedges, heel pads, or insoles whether custom-made or prefabricated; cranial (head) remodeling band for the treatment of positional non-synostotic plagiocephaly; and other protective head gear;
24. **Over-The-Counter Supplies** – Such as ACE wraps, elastic supports, finger splints, Orthotics, and braces; also OTC products not requiring a prescription to be dispensed (e.g., aspirin, antacids, cervical collars and pillows, lumbar-sacral supports, back braces, ankle supports, positioning wedges/pillows, herbal products, oxygen, medicated soaps, food supplements, and bandages) are excluded unless specifically stated as Covered in the Covered Services Section of this Policy or as specifically provided in an optional pharmacy Rider;
25. **Personal Comfort and Convenience Items** – Services such as television, telephone, barber or beauty service, or similar incidental services and supplies; equipment or services for use in altering air quality or temperature; exercise equipment, hot tubs and pools; home services to help meet personal, family, or domestic needs; any costs of enrollment or memberships in a health, athletic or similar club; purchase or rental of household equipment such as, but not limited to, fitness equipment, air purifiers, central or unit air conditioners, humidifiers, dehumidifiers, water purifiers, hypo-allergenic pillows, power assist chairs, mattresses or waterbeds;
26. **Prescription Drugs and Medications** – Prescription drugs and medications that require a prescription and are dispensed at a Pharmacy for outpatient treatment, except as specifically provided in an optional pharmacy Rider to the Policy.
27. **Private Duty Nursing** – Private duty nursing services, nursing care on a full-time basis in Your home, or home health aides;
28. **Reduction or Augmentation Mammoplasty** – Reduction or augmentation mammoplasty is excluded unless associated with breast reconstruction surgery following a Medically Necessary mastectomy resulting from cancer;
29. **Sex Transformation Services** – Services and associated expenses, including hormonal support, for sex transformation operations regardless of any diagnosis of gender role disorientation or psychosexual orientation;
30. **Sexual Dysfunction** – Any device, implant or self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence and anorgasmia;
31. **Smoking Cessation** – Those services and supplies for smoking cessation programs and treatment of nicotine addiction;
32. **Transplant Organ Removal** – Those services and associated expenses for removal of an organ for the purposes of transplantation from a donor who is not an Insured unless the recipient is an Insured and the donor’s medical Coverage excludes reimbursement for organ harvesting; transplant services, screening tests, and any related conditions or complications related to organ donation when an Insured is donating organ or tissue to a non-Insured; and transplant services and associated expenses involving temporary or permanent mechanical or animal organs;
33. **Vision Aids, Associated Services** – Those services and associated expenses for orthoptics or vision training, field charting, eye exercises, radial keratotomy, LASIK or other refractive eye surgery, low vision aids and services.