COVERED SERVICES
(Amended as of 12/15/09)

The Plan covers only those Health Services and supplies that are (1) deemed Medically Necessary, (2) Authorized, if Authorization is required, and (3) not excluded under the exclusions and limitations set forth in Section 8. Health Services are Covered at a reduced or standard percentage under the Out-of-Network benefit outlined in the Schedule of Benefits when Medically Necessary, provided by a Non-Participating Provider, and not excluded as described in Section 7.

The following section, Schedule of Covered Services, provides the Health Services and supplies Covered under this Agreement. The schedule is provided to assist You with determining the level of coverage and Authorization procedures, limitations, and exclusions that apply for Covered Services when determined to be Medically Necessary, subject to the exclusions and limitations set forth in Section 8 and any Copayments, Coinsurance or Deductibles as outlined in Your Schedule of Benefits. All Prior Authorizations and determinations referenced in the Schedule of Covered Services are made by the Plan. If a service is Medically Necessary but not specifically listed and not otherwise excluded, please contact the Plan to confirm whether the service is a Covered Service.

The differences in Coverage between the In-Network and the Out-of-Network benefit levels, including any Coinsurance, Copayment, or Deductible amount You are required to pay for each Covered Health Service is stated in the Schedule of Benefits. The Copayment amount You are required to pay for each Covered Health Service is stated in the Schedule of Benefits. However, if a Member requires Emergency outpatient services and supplies, the required Copayment for Emergency outpatient services and supplies will not apply if Confinement occurs for the same condition within twenty-four (24) hours.

The network of Participating Providers available to You under this Plan is listed in the Provider Directory provided on the Plan website. The Provider Directory is given to Members upon request, and is available on the Plan’s web site. It is therefore important that You carefully review Your Provider Directory. Listing a particular Provider in the Provider Directory is not a guarantee that the particular Provider will be participating at the time You seek Health Services. You must verify the participation status of Providers with the Plan before You obtain Health Services.

Except where noted, these Health Services are Covered when rendered by either Participating or Non-Participating Providers. Please remember that Health Services rendered by Non-Participating Providers will be Covered at the lower Out-of-Network level and Authorized if Authorization is required.

Please note that the Covered Services in the schedule below are subject to all applicable Exclusions of this COC.
<table>
<thead>
<tr>
<th>Service</th>
<th>Covered Service</th>
<th>Exception</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy</td>
<td>Covered Service for allergy testing, diagnosis, treatment, allergy serum, and the administration of injections. Coverage is provided for allergy services and supplies ordered by and provided by or under the direction of a Physician in the Provider's office.</td>
<td>Prior Authorization may be required.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Exclusions:</strong> 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.</td>
</tr>
<tr>
<td>Ambulance</td>
<td>Coverage is provided for Emergency ambulance transportation, when transport by other means is not medically safe, by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be rendered.</td>
<td>Prior Authorization required unless emergent in nature.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>All air or ground ambulance transfer between facilities requires Prior Authorization.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Exclusions:</strong> Ambulance transportation due to the absence of other transportation on the part of the Member is excluded. Non-Medical Emergency ambulance services are excluded regardless of who requested the ambulance service.</td>
</tr>
<tr>
<td>Blood and Blood Products</td>
<td>Covered Service for administration, storage, and processing of blood and blood products in connection with Covered services.</td>
<td><strong>Exclusions:</strong> Those services and associated expenses related to personal blood storage, unless associated with a scheduled surgery. Additionally, fetal cord blood harvesting and storage is not a Covered Service.</td>
</tr>
<tr>
<td>Service</td>
<td>Description</td>
<td>Prior Authorization Required</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>-------------------------------</td>
</tr>
</tbody>
</table>
| **Breast Reconstruction**              | Coverage is provided for breast reconstructive surgery and prosthesis following a medically necessary mastectomy. As required by the Women's Health and Cancer Rights Act (“WHCRA”), if you elect breast reconstruction after a covered mastectomy, benefits will be provided for augmentation and reduction of the affected breast, augmentation or reduction on the opposite breast to restore symmetry, prosthesis, and treatment of physical complications at all stages of the mastectomy, including lymphedema. This also includes nipple reconstruction. In lieu of surgery, coverage is provided for external prosthetic devices. | Prior Authorization required. | **Exclusions:**  
Reduction or augmentation mammoplasties unrelated to a medically necessary mastectomy.  
There is no coverage for surgery performed for removal of breast implants that were originally implanted solely for cosmetic purposes. |
| **Cardiac Rehabilitation Therapy**    | Covered service, but limited to treatment for therapy conditions that in the judgment of your physician and the medical director are subject to significant improvement of your condition through relatively short-term therapy. | Prior Authorization required. | **Limitations:**  
Limited to 36 phase II visits in a 12-week period.  
**Exclusions:**  
Phase III (maintenance phase) cardiac rehabilitation. |
| **Chemotherapy and Radiation Therapy** | Standard chemotherapy and radiation therapy, for the treatment of cancer.     | Prior Authorization may be required. | **Exclusions:**  
Experimental or investigational or non-standard chemotherapy or radiation therapy. |
| Child Health Supervision Services | Coverage is provided for the periodic review of a child’s physical and emotional status by a Physician or pursuant to a Physician’s supervision. A review shall include a history, complete physical examination, development assessment, anticipatory guidance, appropriate immunizations and laboratory tests consistent with prevailing standards, including testing for lead poisoning for children under the age of six (6). Periodic reviews are Covered (up to 20 visits) from the date of birth through the age of eighteen (18) years at the following intervals: birth, two weeks, two month, four months, six months, nine months, twelve months, fifteen months, eighteen months, two years, yearly after age two years until age six (6), and every two years after age six (6) up to age eighteen (18).

Coverage is also provided for the treatment of autism spectrum disorders for Members under twelve (12) years of age. |  |
| Chiropractic Services | Medically Necessary and clinically appropriate Chiropractic therapy is Covered. | Prior Authorization is required.

**Limitations:**

The therapy rendered must be within the Chiropractor’s lawful scope of practice. |  |
Clinical Trials

Coverage for routine patient care costs related to phase I, II, III or IV clinical trials is limited to cancer treatment. The treatment shall be provided in a clinical trial that either:

- Involves a drug that is exempt, under federal regulations, from new drug application; or
- Is approved by the following:
  1. One of the national institutes of health;
  2. The Food and Drug Administration (FDA) in the form of an investigational new drug application;
  3. The Veteran’s Administration or Defense Department.

Routine patient care costs are those costs associated with the provision of health care services including services that are:

1. Typically provided absent a clinical trial;
2. Required solely for the provision of the drug, medical device or service;
3. Required for the clinically appropriate monitoring of the drug, medical device, or service;
4. Provided for the prevention of complication arising from the provision of the drug, medical device, or service; and

Needed for the reasonable and necessary care arising from the provision of the drug, medical device, or service including the complications.

Limitations:
Prior Authorization will be required by the Plan.
Coverage is based on the commercial benefit at the time the Member is enrolled in a clinical study at a participating medical center. Should a patient choose to enroll in a study at a non-participating center, Coverage will be limited to the level that would be incurred at the nearest participating center in the Member’s Service Area. Any case that can be safely delegated to Participating Physicians, in the event that the Member is receiving care by a Non-participating Provider, will be required to receive the In-Network benefit.

Exclusions:
The cost of any non-health care services that a member may require in conjunction with the clinical trial (e.g. transportation, lodging, custodial care) and the administrative costs associated with managing the clinical trial.
### Clinical Trials (cont)
Coverage is excluded for any clinical trials treatment of cancer that are not sanctioned by the listed organizations. Coverage for the cost of investigational drug(s) is excluded. Coverage is also excluded for services not Covered under the Member’s policy for non-investigational treatment (e.g. cosmetic surgery, custodial care) or costs in conjunction with the clinical trial (e.g. transportation, lodging, custodial care).

### Colorectal Cancer Screening
Coverage is provided for a colorectal cancer screening for Members who are fifty (50) years of age and older, Members who are at high risk for colorectal cancer according to the American Cancer Society colorectal cancer screening guidelines, and Members experiencing symptoms of colorectal cancer as determined by their Physician.

Screening shall include:

1. An annual fecal occult blood test; OR
2. An annual fecal immunochemical test in conjunction with a flexible sigmoidoscopy every five (5) years; OR
3. A double-contrast barium enema every five (5) years; OR
   A colonoscopy every ten (10) years.

### Contraceptive Devices
Contraceptive implants & IUD’s are covered. Contraceptive supplies and devices obtained at a pharmacy are determined by the applicable pharmacy Rider.
<table>
<thead>
<tr>
<th>Cosmetic, Plastic and Related Reconstructive Surgery</th>
<th>Services are limited to the surgical correction of congenital birth defects or the effects of disease or injury, which cause anatomical functional impairment, when such surgery is reasonably expected to correct the functional impairment. For purposes of this Agreement, psychological or emotional conditions do not constitute Medical Necessity.</th>
<th>Prior Authorization required.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Services</td>
<td>Coverage benefit limited to the Emergency treatment as a result of trauma resulting in fracture of jaw or laceration of mouth, tongue, or gums. Services are Covered for the removal of tumors and cysts of the jaws, lips, cheeks, tongue, roof and floor of the mouth, and removal of bony growths of the jaw, soft and hard palate and Medically Necessary reconstructive surgery of the jaw for repair of traumatic injury. Separate of, and in addition to, the accident-related dental services described above, there shall also be Coverage for the administration of general anesthesia (regardless of whether the dental services are provided in a Hospital, surgical center or Physician’s office), and Hospital charges for dental care provided to the following Members when Authorized in advance by the Plan and, (1) A child under the age seven (7); (2) A person with a diagnosed serious mental or physical condition; or (3) A person with a significant behavioral problem.</td>
<td>Limited benefit. Prior Authorization required. <strong>Exclusions:</strong> Not a Covered Service for the care, treatment, filling, removal, replacement, repair, or artificial restoration of the teeth (either natural or artificial), root canal, surgery for impacted teeth, surgery involving structures directly supporting the teeth, dental implants or orthodontia. Removal of teeth due to an Injury, prior to radiation or for radionecrosis is also not a Covered Service. General anesthesia and facility charges do not apply to treatment of temporomandibular joint disorders. The diagnosis and treatment for temporomandibular joint disease (TMJ) and craniomandibular joint disease is not Covered unless by an attached Rider.</td>
</tr>
<tr>
<td>Dental Services (cont.)</td>
<td>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,) whether the services are considered to be medical or dental in nature except as provided in this section. Dental x-rays, supplies and appliances (including occlusal splints and orthodontia). Removal of dentigenous cysts, mandibular tori and odontiod cysts are excluded as they are dental in origin.</td>
<td></td>
</tr>
<tr>
<td>------------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Dermatological Services</td>
<td>Covered Service when necessary to remove a skin lesion that interferes with normal body functions or is suspected to be malignant. Prior Authorization may be required. <strong>Exclusions:</strong> The removal or destruction of skin tags is not Covered. Benign pigmented nevi, sebaceous cysts and seborrheic keratosis that cause no functional impairment are not Covered.</td>
<td></td>
</tr>
<tr>
<td>Dialysis</td>
<td>Covered Service for hemodialysis and peritoneal services provided by outpatient or inpatient facilities or at home. For home dialysis, equipment, supplies, and maintenance will be a Covered Service.</td>
<td></td>
</tr>
<tr>
<td>Diabetic Supplies</td>
<td>Coverage includes Plan approved glucose meters (including those for the legally blind), insulin pumps, infusion devices and appurtenances thereto and self-management training (including medical nutrition counseling) used in connection with the treatment of Type I, Type II and gestational diabetes. Coverage also includes diabetes self-management training as Medically Necessary provided by an appropriately licensed health care professional.</td>
<td>Prior Authorization required for insulin pens, pumps, cartridges, extended education classes, and glucose meters. <strong>Limitations:</strong> Disposable insulin syringes, glucose strips, and lancets are Covered under a Pharmacy Rider (if purchased).</td>
</tr>
<tr>
<td>------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME)</td>
<td>Covered Service when determined to be necessary and reasonable for the treatment of an Illness or Injury, or to improve the functioning of a malformed body part, and when all of the following circumstances apply:</td>
<td>Prior Authorization may be required. Upgrades to equipment are the responsibility of the Member.</td>
</tr>
</tbody>
</table>
### Durable Medical Equipment (DME) (cont.)

1. It can withstand repeated use;
2. It is primarily and customarily used to serve a medical purpose;
3. It is generally not useful to a person in the absence of Illness or Injury;
4. It is appropriate for use in the home; and
5. Member is compliant with its use as prescribed by the treating Physician.

There is Coverage for the initial rental and purchase of Durable Medical Equipment when Authorized in advance by the Plan, obtained from a vendor or Provider selected or approved by the Plan, and ordered by or provided by or under the direction of a Provider for use outside a Hospital or SNF. Coverage is provided for Durable Medical Equipment that meets the minimum specifications that are Medically Necessary.

Coverage includes, but is not limited to the following: standard wheelchairs; standard Hospital-type beds; Plan approved glucose meters; continuous passive motion devices after surgery; initial placement of elastic garments; oxygen and the rental of equipment for the administration of oxygen; mechanical equipment necessary for the treatment of chronic or acute respiratory failure (ventilators and respirators).

Coverage will be provided for replacement of Durable Medical Equipment which has become non-functional and non-repairable due to normal, routine wear and tear, medical necessity, or documented growth of a child. Modification costs necessitated by change in the Member's medical condition and considered by the Plan to be Medically Necessary, are Covered.

### Exclusions:

Durable Medical Equipment that does not serve a medical purpose or cannot be used in a Member’s home, equipment that is generally not useful to a person without Illness, Injury or diseases.

The purchase or rental of supplies of common household use such as exercise equipment, air purifiers, central or unit air conditioners, allergenic pillows or mattresses and beds.

Over-the-counter devices and/or supplies (such as ACE wraps, disposable medical supplies, elastic supports, finger splints, Jobst and TEDS stockings, and soft cervical collars).

Advanced versions of devices are not Covered.
### Durable Medical Equipment (DME) (cont.)

| Those repairs, replacement, or maintenance costs for any otherwise Covered DME except as provided as a Covered service; maintenance due to normal wear and tear of items owned by the Member; personal comfort items, including air conditioners, humidifiers and dehumidifiers, even though prescribed by a Physician, unless defined as Covered Services. This exclusion also applies to disposable medical supplies, including but not limited to, feeding bags, and feeding syringes. However, modification or replacement costs necessitated by change in the Member's medical condition and considered by the Plan to be Medically Necessary, are Covered if the original equipment was Covered. |
| Emergency Services | Covered Service as set forth in Section 1.35 and 7.1 below. The Plan definition of “Emergency Services” is found in the definition section. Services and supplies furnished or required to screen and stabilize an Emergency medical condition provided on an outpatient basis at either a Hospital or an Alternate Facility are Covered. An additional Copayment will not apply if a recurrent Emergency Room visit occurs for the same condition within twenty-four (24) hours. | While Emergency Services do not require Prior Authorization from or notification to the Plan, You should notify Your Physician within 48 hours of the onset of the Emergency or the next business day or as soon as physically able. **Limitations:** If You are sent to Surgery from the ER and the facility bills as Outpatient Surgery, Your Outpatient Surgery Copayment or Coinsurance may apply. Please refer to Your Schedule of Benefits. |
| Eyeglasses and Corrective Lenses | Not a Covered Service, except when necessary for the first pair of select eyeglasses or corrective lenses following cataract surgery performed while You are enrolled with the Plan. Coverage is provided for one (1) annual eye examination per Member for the purpose of determining vision loss or disease (including refraction) provided by the Plan’s designated vision provider. | **Limitations:** Coverage at the in-network benefit level is available only when services are provided by the Plan’s designated vision provider. **Exclusions:** Those charges incurred in connection with the provision or fitting of eyeglasses or contact lenses, except for initial placement immediately after cataract surgery. |
| Genetic Counseling | Covered Services include counseling and routine genetic tests performed by the Plan’s reference lab when a Member has delivered or suspected to deliver an infant with suspected genetic abnormalities. | Prior Authorization required. **Exclusions:** Not covered to diagnose multiple fetuses. |
| Genomics | Genomics are Covered only by Prescription Rider for the FDA indication and approved dosing. | **Limitations:**
Covered only by Prescription Rider. Must be Prior Authorized by the Plan. |
| --- | --- | --- |
| Gynecological Examinations | Coverage is provided for one annual self-referred well-woman examination for each female Member, including services, supplies and related tests by an obstetrician, gynecologist or obstetrician/gynecologist, in accordance with the current American Cancer Society guidelines. Diagnosis, including bone mass measurement, treatment and appropriate management for osteoporosis is provided when determined to be Medically Necessary by a physician. Bone mass measurement is cover testing is Covered only for spine or pelvic testing. Coverage is provided for an annual chlamydia screening for Members the age of twenty-nine (29) and younger. | **Exclusions:**
Peripheral bone mass measurement testing is not Covered. |
<p>| Health Education | Covered Service includes instructions on achieving and maintaining physical and mental health, and preventing Illness and Injury. | Health education does not require Prior Authorization by the Plan when provided in the Physician’s office. |
| Hearing Screenings | One (1) annual hearing screening per Member for determining hearing loss is Covered. Medically Necessary treatment for hearing loss is also Covered. Hearing aids are Covered up to an amount as specified in Your Schedule of Benefits. | This benefit will be subject to the same durational limits, dollar limits, Copayment, Deductible, and Coinsurance as other Covered services. |</p>
<table>
<thead>
<tr>
<th>Services</th>
<th>Covered Service when <strong>all</strong> of the following requirements are met:</th>
<th>Prior Authorization required.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Care</td>
<td>(1) The service is ordered by a Physician; (2) Services required are of a type which can only be performed by a licensed nurse, physical therapist, speech therapist, or occupational therapist; (3) The services are a substitute or alternative to Hospitalization; (4) Part-time intermittent services are required; (5) A treatment plan has been established and periodically reviewed by the ordering Physician; (6) The services are Authorized by the Plan; and (7) The agency rendering services is Medicare certified and licensed by the State of location; and (8) The Member is homebound.</td>
<td></td>
</tr>
<tr>
<td>Hospice</td>
<td>Coverage is provided for hospice care rendered by a Provider for treatment of a terminally ill Member when Authorized by Your Physician. Skilled care through a hospice program includes supportive care involving the evaluation of the emotional, social and environmental circumstances related to or resulting from the Illness, and guidance and assistance during the Illness for the purpose of preparing the Member and the Member’s family for imminent death when the Member has a prognosis of six (6) months or less to live.</td>
<td>Prior Authorization required.</td>
</tr>
</tbody>
</table>
### Immunizations

Immunizations are Covered for children pursuant to the Plan’s criteria, which uses national standards (approved by the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, the American Academy of Family Physicians, and the Guide to Clinical Preventative Services, Report of the United States Preventative Services Task Force) to establish eligibility guidelines. Adult immunizations are Covered as per guidelines of the Center for Disease Control (CDC) and the U.S. Taskforce of Preventive Guidelines. This program is fully compliant with the minimum Coverage requirements of State law. Please refer to the Member Handbook for further information on Covered immunizations. Immunizations for children shall be exempt from any Copayment, Coinsurance, Deductible or dollar limitation.

### Prior Authorization

Prior Authorization required for immunizations other than routine childhood immunizations (e.g., Lyme Disease).

### Implants and Related Health Services

Implant devices and related implantation Health Services including penile implants (unless prescribed to treat impotence which is psychological in origin), implants for the purpose of contraception, and implants for the delivery of Prescription Medication when provided by or under the direction of Your Physician, in accordance with the Plan's guidelines and approved in advance by the Plan, are Covered.

### Prior Authorization

Prior Authorization required.

**Limitations:**

Penile implants are limited to one (1) per Lifetime.

**Exclusions:**

- There is no Coverage for either dental, breast, cochlear (including services related to cochlear implants), or nanometric implants.

This list also includes, but is not limited to, VNS (vagal nerve stimulator) implants.

Covered implants, except when necessitated due to a change in the Member's medical condition.
| Infertility | Medically Necessary diagnostic studies which are related to Infertility are Covered once per Lifetime. Members may self-refer to any obstetrician, gynecologist or obstetrician/gynecologist for Covered services. Coverage for in vitro fertilization when:  
1. The Member’s oocytes are fertilized with the spouse’s sperm; and  
2. The Member and the Member’s spouse have a history of unexplained infertility of at least two (2) years duration; or  
3. The infertility is associated with endometriosis, exposure in utero to Diethylstilbestrol (DES), blockage of or removal of one of both fallopian tubes not a result of voluntary sterilization, or abnormal male factors contributing to the infertility; and  
4. Member has been unable to obtain a successful pregnancy through less costly infertility treatment. | Prior Authorization required.  
**Limitations:** Benefit is limited to $15,000 per Lifetime.  
**Exclusions:** Therapeutic services and treatment related to Infertility are not Covered except by an attached Rider to the Agreement. |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Injectable Medications</td>
<td>Medically Necessary injectable medications are Covered when FDA-approved and medically appropriate, subject to limitation by pre-Authorization and substitute Coverage by therapeutically interchangeable drugs, according to clinical guidelines used by the Plan. For Coverage of medications that are self-injectable, please see “Self-Injectable Medications” in this Section.</td>
<td>Prior Authorization required.</td>
</tr>
<tr>
<td>Inpatient Hospital Care</td>
<td>Coverage includes: general nursing care; use of operating room, surgical and anesthesia services and supplies; blood and blood products; ordinary casts, splints and dressings; all drugs and oxygen used in Hospital; laboratory and X-ray examinations; electrocardiograms; Semi-private Accommodations, Intensive Care Unit, and Coronary Care Unit. Consistent with the Plan’s utilization management policy, all acute care Hospital admissions and continued stays are reviewed for Medical Necessity during the inpatient stay. Coverage is dependent on the establishment of Medical Necessity for the care. If the Hospital stay or portion thereof is determined not to be Medically Necessary, Your Provider will be notified that Coverage will cease. Certain Health Services rendered during a Member’s Confinement are subject to separate benefit restrictions and/or Copayments as described in the Schedule of Benefits and Schedule of Exclusions.</td>
<td>Prior Authorization required unless Emergency admission. <strong>Exclusions:</strong> Except where the Plan has given specific Authorization, You must be admitted to a Participating Hospital and be under the care of a Participating Provider to be eligible to receive In-Network level of benefits for non-Emergency Covered Services. Those personal comfort and convenience items or services such as television, telephone, barber or beauty service, guest service and similar incidental services and supplies. Additional elective, not Medically Necessary surgical procedures are not Covered.</td>
</tr>
<tr>
<td>Laboratory Services</td>
<td>Covered Service.</td>
<td>You may have a Copayment, Coinsurance and Deductible depending on Your benefits. Please refer to Your Schedule of Benefits.</td>
</tr>
</tbody>
</table>
| Mastectomy | Medically Necessary mastectomies are Covered. If a Member elects breast reconstruction following a Medically Necessary mastectomy, the following benefits are also Covered:  
- Reconstruction of the affected breast;  
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;  
- Prostheses; and  
- Treatment of physical complications at all stages of the mastectomy, including lymphedemas. | Prior Authorization required.  
**Limitations:**  
Two (2) Mastectomy bras per calendar year/Contract Year.  
Surgery to establish symmetry must occur within five (5) years of the date the reconstructive surgery was performed. |
<table>
<thead>
<tr>
<th>Medical Complications</th>
<th>Complications arising from Medically Necessary surgery regardless of the membership status at the time of surgery. Complications of pregnancy will be Covered.</th>
<th>Prior Authorization Required. <strong>Exclusions:</strong> If complications occurred when You did not follow the course of treatment prescribed by Your Provider, although the requested service may be Medically Necessary, or if the complication is from a non-Covered Service, the requested service will not be Covered, including, but not limited to, complications as a result of a clinical trial or experimental procedure.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Services in a Physician's Office</td>
<td>Coverage is provided for services and supplies ordered and provided by or under the direction of Your Physician in the Physician's office, including preventive medical care such as well-baby care, routine physical examinations, and Immunizations. Certain Health Services provided in a Physician's office are subject to separate benefit restrictions and/or Copayments as described elsewhere in this COC or in the Schedule of Benefits.</td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td>Covered with an attached Rider only.</td>
<td></td>
</tr>
<tr>
<td>Newborn Care</td>
<td>The Covered Services for eligible newborn children shall consist of Coverage for Injury or Illness, including Medically Necessary care or treatment of medically diagnosed congenital defects, birth abnormalities, or prematurity, and transportation costs of the newborn to and from the nearest facility that is appropriately staffed and equipped to treat the newborn's condition. Coverage is provided for all newborns to be tested or screened for phenylketonuria (PKU), hypothyroidism, galactosemia, sickle cell anemia and all other disorders of metabolism for which screening is performed by or for the State of Arkansas. Routine nursery care for a well newborn child is Covered up to five (5) full days or until the mother is discharged whichever is the lesser period of time. Coverage is also provided for newborn hearing screening examinations, any necessary re-screening, audiological assessment and any requisite follow-up.</td>
<td>Prior Authorization is required for non-emergency or non-urgent transportation to another facility.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Nutritional Counseling</td>
<td>Covered Service when: (1) provided by a Registered Dietician or a Physician and (2) in connection with diabetes, coronary artery disease and hyperlipidemia.</td>
<td></td>
</tr>
<tr>
<td>Oral Surgery and Diseases of the Mouth</td>
<td>Coverage includes only Authorized oral surgical services limited to the reduction or manipulation of fractures of facial bones; excision of lesions of the mandible, mouth, lip, or tongue; incision of accessory sinuses, mouth, salivary glands, or ducts; reconstruction or repair of the mouth or lip necessary to correct anatomical functional impairment caused by congenital defect. Coverage is provided for diseases of the mouth, unless the condition is due to dental disease or of dental origin.</td>
<td>Prior Authorization required. <strong>Exclusions:</strong> Removal of dentiginous cysts, mandibular tori and odontoid cysts are excluded as they are dental in origin. Removal of teeth as a complication of radionecrosis is not a Covered benefit.</td>
</tr>
<tr>
<td>Outpatient Diagnostic Tests and Therapeutic Treatments</td>
<td>Coverage includes services and supplies for prescheduled diagnostic tests and therapeutic treatments provided under the direction of Your Physician at a Hospital or Alternate Facility.</td>
<td>Prior Authorization may be required.</td>
</tr>
<tr>
<td>Service</td>
<td>Description</td>
<td>Authorization Required</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>Coverage is provided for services and supplies for Emergent, Prior Authorized, and prescheduled outpatient surgery provided under the direction of Your Physician at a Hospital or Alternate Facility.</td>
<td>Prior Authorization required.</td>
</tr>
<tr>
<td>Pelvic Examinations and Pap Smears</td>
<td>Coverage is provided for a self-referred pelvic examination and cervical screening for asymptomatic women, in accordance with the American Cancer Society guidelines.</td>
<td></td>
</tr>
</tbody>
</table>
| Phenylketonuria (PKU) or any other Amino and Organic Acid Inherited Disease Food | Coverage is provided for medical foods and low protein modified food products for treatment of a Member diagnosed with PKU, galactosemia, organic acidemias and disorders of amino acid metabolism if:  
   1. The products are medically necessary and prescribed and administered under the direction of a licensed Physician; and  
   The cost of the food and food products for a Member exceeds the income tax credit of $2,400. | Prior Authorization required. |
| Podiatry                                     | Covered Service when determined to be Medically Necessary.  
   Covered Service for regular foot exams if You have diabetes, or when otherwise determined to be Medically Necessary. | Prior Authorization may be required.  
   **Exclusions:**  
   Foot care in connection with clipping nails or treating corns, calluses, flat feet, fallen arches or chronic foot strain.  
   Medical or surgical treatment of onychomycosis (nail fungus). Shoe inserts or Orthotics are also excluded. |
<table>
<thead>
<tr>
<th>Preventive, Diagnostic and Treatment Services</th>
<th>Office visits to a Your Physician for Covered Services and includes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Preventive care, including well-baby care and periodic check-ups according to the preventive care guidelines adopted by the Plan. The Plan’s guidelines are available in your Member Handbook, on the Plan’s website or from Member Services upon request.</td>
<td></td>
</tr>
<tr>
<td>• Diagnosis and treatment of Illness or Injury.</td>
<td></td>
</tr>
<tr>
<td>• Consultations with Specialists.</td>
<td></td>
</tr>
<tr>
<td>• Laboratory tests</td>
<td></td>
</tr>
<tr>
<td>Prostate Specific Antigen (PSA) test, and digital rectal examinations, for the early detection of prostate cancer for men aged fifty (50) and over and other men if a Physician determines that early detection for prostate cancer is medically necessary.</td>
<td></td>
</tr>
<tr>
<td>A baseline mammogram will be covered for women between thirty-five (35) and forty (40), every one (1) to two (2) years, or more frequently based on the recommendation of the woman’s physician, for women between forty (40) and forty-nine (49), and yearly age fifty (50) and older. Mammograms will be Covered more frequently upon the recommendations of the woman’s Physician.</td>
<td></td>
</tr>
<tr>
<td>Diagnosis, including bone mass measurement, treatment and appropriate management for osteoporosis is provided when determined to be Medically Necessary by a physician.</td>
<td></td>
</tr>
<tr>
<td>Prostate Screening</td>
<td>Coverage is provided for a prostate-specific antigen (PSA) exam and digital rectal exam for the early detection of prostate cancer for men aged fifty (50) and over and other men if a Physician determines that early detection for prostate cancer is Medically Necessary.</td>
</tr>
<tr>
<td>Prosthetic and Orthotic Devices</td>
<td>Coverage is provided for the initial purchase of Orthotic Appliances and Prosthetic Devices following the onset or initial diagnosis of the condition for which the device is required. These services must be Authorized in advance by the Plan and obtained for use outside a Hospital or a SNF. Coverage is provided for Orthotic Appliances, splints and braces, including necessary adjustments to shoes to accommodate braces (dental braces are excluded). Coverage is provided for Prosthetic Devices, including but not limited to, purchase of artificial limbs, breasts, and eyes, which meet the minimum requirements or specifications which are Medically Necessary for treatment, limited to the basic functional device which will restore the lost body function or part. For Prosthetic Device placements requiring a temporary and then a permanent placement only one (1) device will be Covered. Shoe inserts or Orthotics will be Covered only if the Member has diabetes to prevent complications associated with diabetes OR the Orthotic is needed for a shoe that is part of a brace. Coverage will be provided for replacement of Prosthetic Devices, which become non-functional and non-repairable due to normal, routine wear and tear, Medical Necessity or documented growth of a child. Modification costs necessitated by change in the Member's medical condition and considered by the Plan to be Medically Necessary, are Covered.</td>
</tr>
<tr>
<td>Prosthetic and Orthotic Devices (cont)</td>
<td>Orthotics and Prosthetics will be replaced yearly for documented growth in a child requiring replacement, but not for changes due to obesity. Eye Prosthetics will be Covered for replacement every five (5) years with exceptions allowed when documentation supports Medical Necessity for more frequent replacement. Polishing and resurfacing is Covered on a yearly basis.</td>
</tr>
<tr>
<td>Pulmonary Rehabilitation Therapy</td>
<td>Covered Service, but limited to treatment for conditions that in the judgment of Your Provider and the Medical Director are subject to significant improvement of Your condition through relatively short-term therapy.</td>
</tr>
<tr>
<td>Radiology</td>
<td>Covered Service.</td>
</tr>
<tr>
<td>Reconstructive Surgery</td>
<td>Covered Service for Medically Necessary:  - Surgery which is incidental to an Injury, Illness or congenital anomaly when the primary purpose is to restore normal physiological functioning of the involved part of the body; or  - Surgery that substantially improves functioning of any malformed body part.</td>
</tr>
</tbody>
</table>
| Rehabilitation Services and Supplies | Coverage is provided for short-term inpatient or outpatient (whichever is Medically Necessary) rehabilitation services which are expected to result in significant functional improvement within sixty (60) days of the Member's condition, limited to physical therapy, occupational therapy, and speech therapy. Rehabilitation services include physical therapy, occupational therapy, and speech therapy. See Your Schedule of Benefits for limitations. Outpatient rehabilitation services must be provided under the direction of Your Physician and Authorized in advance by the Plan. Coverage includes services, supplies, and related Physician and facility charges. | Prior Authorization required. **Exclusions:**
1. Rehabilitative services provided for long-term, Chronic Medical Conditions.
2. Rehabilitative services whose primary goal is to maintain Your current level of function, as opposed to improving Your functional status.
3. Rehabilitative services whose primary goal is to return You to a specific occupation or job, such as work-hardening or work-conditioning programs.
4. Educational or vocational therapy, schools or services designed to retrain You for employment.
5. Rehabilitative services whose purpose is to treat or improve a developmental or a learning disability or delay, mental retardation, cerebral palsy, or congenital anomalies. |
| Rehabilitation Services and Supplies (cont.) | 6. Rehabilitation services that are experimental or have not been shown to be clinically effective for the medical condition being treated.  
7. Alternative rehabilitation services (e.g., massage therapy).  
8. Fees or costs associated with services that are primarily exercise. Examples include, but are not limited to, membership fees for health clubs, fitness centers, weight loss centers or clinics, or home exercise equipment.  
9. Health Services for the diagnosis and treatment of chronic brain Injury, including augmentative communication devices, developmental delay, mental retardation or cerebral palsy are not Covered. |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Second Opinion</td>
<td>Covered Service as per Section 2.4 of this COC.</td>
</tr>
<tr>
<td>Services Provided to Residents of Long-term Care Facilities</td>
<td>If the Member is a resident of a long-term care facility licensed by Arkansas or a continuing care retirement community, such Member has the option of receiving the services Covered by this provision in the long-term care facility that serves as the Member’s primary residence if the following conditions apply:</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>• The facility is willing and able to provide the Covered Service to the Member;</td>
<td>• The facility and its Providers meet the requisite licensing and training standards required under Arkansas law;</td>
</tr>
<tr>
<td>• The facility is certified through Medicare; and</td>
<td>• The facility and its Providers agree to abide by the terms and conditions of the Plan’s contracts with similar Providers, abide by patient protection standards and requirements imposed by state and federal law, and meet the quality standards of the Plan for similar Providers.</td>
</tr>
<tr>
<td>• The services Covered under this provision include, but are not limited to, skilled nursing care, rehabilitative and other therapy services, and post-acute care, as needed.</td>
<td>The Plan may utilize Participating Providers to deliver the services Covered under this provision in the Member’s resident facility.</td>
</tr>
</tbody>
</table>


| Skilled Nursing Facility Services | Coverage is provided for Confinement (on a Semi-private Accommodations basis) and medical services and supplies provided under the direction of a Your Physician in a Skilled Nursing Facility. Health Services rendered in a Skilled Nursing Facility are Covered only for the care and treatment of an Injury or Illness which cannot be safely provided in an outpatient setting, as determined by the Plan. | Prior Authorization required. **Limitations:** Coverage in a Skilled Nursing Facility is subject to a calendar year/Contract Year limitation and medical necessity, as specified in the Schedule of Benefits. Certain Health Services (e.g. lab, x-ray, physical therapy, etc.) rendered during a Member's Confinement are subject to separate benefit restrictions and/or Copayments described elsewhere in this COC or in the Schedule of Benefits. |
| Surgical Services | Surgical services and other related medical care ordered by and provided by or under the direction of a Your Physician in a Hospital, Participating SNF or Alternate Facility are Covered. | Prior Authorization required. For oral surgery services, see Dental. |
| Termination of Pregnancy | Termination of pregnancy after the first trimester is Covered Service only if the life or physical health of the mother or fetus would be endangered if the fetus were carried to term, or if fetal abnormalities incompatible with life are detected. Not a covered service for Individual | Prior Authorization required. |
Transplants

Services related to Medically Necessary organ transplants are Covered when approved by the Plan and performed at a Coventry Transplant Network facility approved by the Plan.

Donor screening tests are Covered and are subject to a Lifetime benefit maximum of $10,000-$20,000.

Coverage shall include the treatment of breast cancer by autologous bone marrow transplants or stem cell transplants when performed pursuant to nationally accepted peer review protocols utilized by breast cancer treatment centers experienced in autologous bone marrow transplants or stem cell transplants.

Coverage for human leukocyte antigen (HLA) testing for bone marrow transplantation is included once per Lifetime. Reimbursement shall be no greater than seventy-five ($75) dollars and the Member must sign an informed consent which authorizes the results of the test to be used for participation in the National Marrow Donor Program.

A separate authorization is required for each phase of the transplant.

Limitations:
There is no Coverage under the Plan’s guidelines for transplantation Health Services for the donor under this Plan if the recipient is not a Member.

However, if the recipient is a Member, then Health Services and supplies necessary for harvesting for a Covered transplant will be Covered. Coverage for immunosuppressant drugs will be provided under the Member’s pharmacy Rider (if purchased).

Exclusions:
Services received at a non-Coventry Transplant Network Facility will not be Covered.

Bone marrow and stem cell Transplants unless Covered by a Supplemental Rider.

Any transplant service deemed Experimental or Investigational will not be Covered.
<table>
<thead>
<tr>
<th>Urgent Care Services</th>
<th>Coverage is provided for Urgent Care Services provided at an Alternate Facility such as an urgent care center or after hours facility.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well Child Care, Including Physician Hospital Visits for Newborns</td>
<td>Physician Hospital visits for eligible newborn babies are Covered up to thirty-one (31) days after birth. See Newborn Care in this section. Also included are periodic reviews of a child's physical and emotional status by or under the supervision of Your Provider. Newborns, infants, and children become eligible for these reviews pursuant to the Plan's criteria, which is based on national standards, as defined by the Guide to Clinical Preventative Services, Report of the United States Preventative Services Task Force. See &quot;Immunizations” in this section for information about child immunizations.</td>
</tr>
</tbody>
</table>
EXCLUSIONS AND LIMITATIONS
(Amended 5/11/09)

The following items are excluded from Coverage both In-Network and Out-of-Network:

1) Any service or supply that is not Medically Necessary;

2) Any service or supply that is not a Covered service or that is directly or indirectly a result of receiving a non-Covered Service;

3) Any service or supply for which You have no financial liability or that was provided at no charge; those Health Services for which the Member has no legal obligation to pay or for which a charge would not ordinarily be made in the absence of Coverage under the Agreement;

4) Procedures and treatments that the Plan determines to be Experimental or Investigational as defined in Section 1.36;

5) Court-ordered services or services that are a condition of probation or parole;

6) Those Health Services otherwise Covered under the Agreement related to a specific condition when a Member has refused to comply with, or has terminated the scheduled service or treatment against the advice of a Your Provider or the Mental Health/Substance Abuse Designee;

7) Those Health Services otherwise Covered under the Agreement, but rendered after the date individual Coverage under the Agreement terminates, including Health Services for medical conditions arising prior to the date individual Coverage under the Agreement terminates; and

8) Those Health Services rendered outside the scope of a Participating or Non-Participating Provider's license, rendered by a Provider with the same legal residence as a Member, or rendered by a person who is a member of a Member's family, including spouse, brother, sister, parent, step-parent, child or step-child.

9) Health Services for Dependents of a Dependent are excluded except if (a) included specifically by as set forth in Section 3.1 “Dependent Eligibility”.

Specifically excluded services include, but are not limited to, the following:

1) Abortion - Elective Abortion;

2) Acupuncture - Those acupuncture services and associated expenses which include, but are not limited to, the treatment of certain painful conditions or for anesthesia purposes;
3) 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;

4) Alternative Therapies Alternative - therapies, including, but not limited to, recreational, educational, music or sleep therapies and any related diagnostic testing, massage

5) Ambulance Service - Ambulance transportation due to the absence of other transportation on the part of the Member is excluded. Non Medical Emergency ambulance services are excluded regardless of who requested the services;

6) Augmentative Communication Devices, including but not limited to devices utilizing word processing software and voice recognition software;

7) Autopsy - Those services and associated expenses related to the performance of autopsies to the extent that payment for such services is, by law, covered by any governmental agency as a primary plan;

8) Behavior modification - Those behavioral or educational disorder services and associated expenses related to confirmation of diagnosis, progress, staging or treatment of behavioral (conduct) problems, ADD, Oppositional Defiant Disorder, learning disabilities, developmental delays, mental retardation, anoxic birth injuries, birth defects, cerebral Injury, non-acute head injuries, or cerebral palsy;

9) Biofeedback;

10) Blood Storage - Those services and associated expenses related to personal blood storage, unless associated with a scheduled surgery. Additionally, fetal cord blood harvesting and storage is not a Covered service;

11) Braces and supports needed for athletic participation or employment;

12) Care rendered to You by a relative;

13) Charges resulting from Your failure to appropriately cancel a scheduled appointment;

14) Christian Science Practitioners - Christian Science Practitioners’ services are excluded with the exception of the Medicare certified Religious Non Medical Health Care Institutions (RNHCIs) Services. The services and supplies provided by a naturopath are also excluded;

15) Cochlear Implants and related services;

16) Cosmetic Services and Surgery - Those Health Services, associated expenses, or complications resulting from Cosmetic Surgery are not Covered. Cosmetic procedures include, but are not limited to, pharmacological regimens, plastic surgery, blepharoplasty, and non-Medically Necessary dermatological procedures and Reconstructive Surgery. Cosmetic procedures are those procedures that improve physical appearance, but do not correct or materially
improve a patho-physiological function and are not Medically Necessary except when the procedure is needed for prompt repair of accidental injury or significantly improve the function of a congenital anomaly. Breast reconstruction following a Medically Necessary mastectomy is not considered Cosmetic and is a Covered Service;

17) Counseling Services and treatment related to religious counseling, marital/relationship counseling, vocational or employment counseling, and sex therapy are not Covered Services;

18) Custodial Care, domiciliary care, private duty nursing, respite care or rest care. This includes care that assists Members 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. Custodial Care also includes any health-related services that do not seek to cure, are provided during periods when the medical condition of the patient is not changing or that do not require continued administration by trained medical personnel;

19) 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,) whether the services are considered to be medical or dental in nature except as provided in Section 6 “Covered Services” of this COC. Dental x-rays, supplies and appliances (including occlusal splints and orthodontia The diagnosis and treatment for temporomandibular joint disease (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;

20) Dental Surgery and Implants - Dental implants are excluded. Removal of dentiginous cysts, mandibular tori, and odontoid cysts are excluded as they are dental in origin. Removal of teeth as a complication of radionecrosis or to prevent systemic infection is not a Covered Service;

21) Durable Medical Equipment (“DME”), Repairs or Replacement - Those repairs or replacement costs for any otherwise Covered DME; maintenance due to normal wear and tear of items owned by the Member; personal comfort items including, but not limited to air conditioners, humidifiers and dehumidifiers, bathtub assistive devices, wheelchair lifts; athletic equipment. There is also no Coverage for the equipment, device, or appliance if the Member is non-compliant with its’ use as prescribed by the Member’s Physician.

22) Educational Services - Those services for remedial education including, but not limited to, evaluation or treatment of learning disabilities, minimal brain dysfunction, cerebral palsy, mental retardation, developmental and learning disorders and behavioral training;

23) Equipment or services for use in altering air quality or temperature;
24) Educational testing or psychological testing, unless part of a treatment program for Covered services;

25) 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, even when the medical or surgical treatment has been provided by the Plan for the condition resulting in the scar, are not Covered;

26) Eligible Expenses - Any otherwise Eligible Expenses that exceed the maximum allowance or benefit limit;

27) Enteral Feeding Food Supplement - The cost of outpatient enteral tube feedings or formula and supplies except when used for Phenylketonuria (PKU) or any other amino and organic acid inherited disease is not Covered, except as defined as a Covered Service;

28) 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 services relating to judicial or administrative proceedings or orders or which are conducted for purposes of medical research or to obtain or maintain a license of any type;

29) Experimental Services - Those Health Services, associated expenses, or complications resulting from Experimental, Investigational, controversial, or unproven Services, treatments, devices and pharmacological regimens, including, but not limited to methadone treatment. The fact that an Experimental, Investigational or unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or unproven in the treatment of that particular condition. Also excluded are those Health Services and associated expenses for clinical trials that are not deemed to be automatically qualified to receive Medicare coverage except as applicable to state law;

30) Exercise equipment;

31) Eye Glasses and Contact Lenses - Those charges incurred in connection with the provision or fitting of eye glasses or contact lenses, except for initial placement immediately after cataract surgery;

32) Eye Services - Those Health Services and associated expenses for orthoptics, eye exercises, blepharoplasty, radial keratotomy, LASIK and other refractive eye surgery;
33) Food or food supplements;
34) 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). Nail debridement and clipping (except diabetic members) is also excluded;
35) Growth Hormone – Growth hormone therapy for any condition, except in children less than 18 years of age which have been appropriately diagnosed to have a documented growth hormone deficiency. However, this exclusion does not apply to growth hormone therapy for the treatment of Turner’s Syndrome or to HIV wasting syndrome;
36) 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, wigs, hairpieces and hair prostheses;
37) Health and Athletic Club Membership Equipment – Any cost of enrollment in a health, athletic or similar club is not Covered;
38) Hearing Services and Supplies Those services and associated expenses for cochlear implants, hearing therapy and any related diagnostic hearing tests except as provided in Section 6 (Covered Services) or attached Rider;
39) Home services to help meet personal, family, or domestic needs;
40) Household Equipment and Fixtures- 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, hypoallergenic pillows, power assist chairs, mattresses or waterbeds and electronic communication devices;
41) Hypnotherapy is not Covered;
42) Implant – Health Services and associated expenses for implants are excluded, except as specifically stated in Section 6 “Covered Services” of this COC. There is no Coverage for repair or replacement for any otherwise Covered implant and Health Services related to repair or replacement, except when necessitated due to a change in Member’s medical condition. Penile implants for the treatment of impotence having a psychological origin are not Covered. Dental implants are not Covered;
43) Immunizations for travel or employment;
44) Infertility Services - Those Health Services and associated expenses for the treatment of Infertility including, but not limited to, artificial insemination, ICSI (intracytoplasmic sperm injection), or in vivo fertilization, gamete intrafallopian transfer (GIFT) procedures, zygote intrafallopian transfer (ZIFT) procedures, embryo transport, reversal of voluntary sterilization, surrogate parenting, selective reduction, cryo preservation, travel costs, donor eggs or semen and related costs including collection and preparation, non-Medically Necessary amniocentesis, and any Infertility treatment deemed...
Experimental or Investigational. Additionally, pharmaceutical agents used for the purpose of treating Infertility are not Covered, unless Covered by a Rider;

45) Lesions – The removal or destruction of skin tags are not Covered. Benign pigmented nevi, sebaceous cysts and seborrheic keratosis that cause no functional impairment;

46) Maintenance Therapy - There is no Coverage for Maintenance Therapy;

47) Maternity care, including term, premature labor and delivery, cesarean sections, abortions, and prenatal and postnatal services. Complications of pregnancy however are covered.

48) Medical Record Costs

49) Medical Complications – Complications arising directly or indirectly from a non-Covered Service;

50) Military Health Services – Those Health Services for treatment of military service-related disabilities when the Member is legally entitled to other Coverage and for which facilities are reasonably available to the Member; or those Health 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; or Health Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country;

51) Miscellaneous Service Charges - Telephone consultations, charges for failure to keep a scheduled appointment or any late payment charge;

52) Nanometrics – There is no Coverage for Nanometrics implants;

53) 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 are excluded;

54) Non-Prescription Drugs – Over-the-counter drugs and medications incidental to outpatient care and Urgent Care Services are excluded. Take home drugs and medications resulting from an Emergency visit or Hospital stay are Covered;

55) Nutritional-based Therapy – Nutritional-based therapies except for treatment of phenylketonuria (PKU) and for nutritional deficiencies due to short bowel syndrome and HIV. Oral supplements and/or enteral feedings, either by mouth or by tube, are also excluded;

56) Obesity Services - Those Health 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 Health Services of a similar nature are not Covered. Health Services and associated expenses for weight loss programs, nutritional supplements, appetite suppressants, and supplies of a similar nature are not Covered;

57) Occupational Injury- Those Health Services and associated expenses related to the treatment of an Occupational Injury or Illness for which the Member is eligible to receive treatment under any Workers' Compensation or Occupational disease laws or benefit plans;

58) Oral Surgery Supplies – Those supplies required as part of an orthodontic treatment program, required for correction of an occlusal defect, encompassing orthoganathic or prognathic surgical procedures, or removal of symptomatic bony impacted teeth;

59) Orthodontia and related services;

60) Orthotic Appliances and Prosthetic Devices and Repairs – No Coverage is provided for repair, or duplicates nor is Coverage provided for Health Services related to any repair. Over the counter braces, splints and Orthotics are not Covered. Advanced versions of devices are not Covered. Orthopedic shoes are not Covered. Cranial helmets are not Covered, unless the congenital defect of the skull adversely effects normal brain, auditory, visual or central nervous system development. Shoe inserts are not Covered unless the Member has diabetes with demonstrated peripheral neuropathy or the insert is needed for a shoe that is part of a brace;

61) Other Coverage Services – Those Health Services for which other Coverage is required by federal, state, or local law to be purchased or provided through other arrangements, including, but not limited to, Coverage required by workers’ compensation, no-fault automobile insurance or other similar legislation;

62) Over-the-counter supplies such as ACE wraps, elastic supports, finger splints, Orthotics, and braces;

63) Personal Comfort - Those personal comfort and convenience items or services such as television, telephone, barber or beauty service, guest service and similar incidental services and supplies;

64) Physical, Psychiatric, or Psychological Examinations or Testing, Etc. Those physical, psychiatric, neuropsychological, or psychological examinations or testing, or vaccinations, immunizations, or treatments and associated expenses, when such services are for purposes of obtaining, maintaining or otherwise related to education, employment, insurance, travel, marriage or adoption, senile dementia and Alzheimer’s, or relating to judicial or administrative proceeds or orders, or which are conducted for purposes of medical research, or to obtain or maintain a license or official document of any type;
65) Pre-existing Medical Conditions are excluded as described in Section 2.

66) Prescription Medication

- Those prescription medications for outpatient treatment, except as Covered under a Prescription Rider to the Agreement. Specifically excluded from Coverage are:
- Non-prescription contraceptive devices (e.g., condoms, spermicidal agents);
- Any outpatient prescription drug which is to be administered, in whole or in part, while a Member is in a Hospital, medical office or other health care facility;
- Compounded prescriptions whose ingredients do not require a prescription;
- Cost for packaging required for drugs dispensed in nursing homes;
- Dietary supplements, appetite suppressants, and other drugs used to treat obesity or assist in weight reduction;
- Drugs and products for smoking cessation (e.g., Nicorette gum and smoking cessation skin patches);
- Drugs and products used for Cosmetic purposes;
- Drugs and products used for fertility;
- Drugs and products used to enhance athletic performance including testosterone gel, and growth hormones;
- Drugs used primarily for hair restoration;
- Experimental products, or drugs prescribed for Experimental indications, including those labeled “Caution – Limited by Federal Law to Investigational Use”;
- Injectable and self-injectable medications, except those designated by the Plan;
- Over-the-counter (OTC) products not requiring a prescription to be dispensed (e.g., aspirin, antacids, herbal products, oxygen, medicated soaps, food supplements, and bandages);
- Legend drugs for which there is a non-Prescription Drug alternative (e.g., OTC);
• Prescription Drugs related to a non-Covered Service;

• Products not approved by the FDA, medications with no FDA approved indications;

• Vitamins and minerals (both OTC and legend), except legend prenatal vitamins for pregnant or nursing females, liquid or chewable legend pediatric vitamins for children;

• Prescription Medications taken for travel;

• Replacement prescriptions resulting from loss or theft;

• Any non-FDA approved medication usage, including, but not limited to medical condition, dosage, age limitations, or route of administration;

67) Private Duty Nursing - Private duty nursing services, nursing care on a full-time basis in Your home, or home health aides;

68) Private inpatient room, unless Medically Necessary or if a Semi-private room is unavailable;

69) Radial keratotomy, LASIK, and blepharoplasty;

70) Reduction or Augmentation Mammaplasty - Reduction or augmentation mammaplasty is excluded unless associated with Reconstructive Surgery following a Medically Necessary mastectomy. Breast reduction for male physiologic gynecomastia is also excluded;

71) Rehabilitative Services – Maintenance therapy and those rehabilitative services and associated expenses which are not short-term rehabilitative services;

72) Robotics;

73) Sex Transformation Services – Health Services and associated expenses for sex transformation operations regardless of any diagnosis of gender role disorientation or psychosexual orientation, including any treatment or studies related to sex transformation. Also excluded is hormonal support for sex transformation;

74) Sexual Dysfunction – Self-administered prescription medication and penile prostheses for the treatment of sexual dysfunction, including erectile dysfunction, impotence and anorgasmia;

75) Skin Abrasion, Etc. - Salabrasion, chemosurgery, laser surgery or other such skin abrasion procedures associated with the removal of scars, tattoos, actinic changes and/or which are performed as a treatment for acne even when the medical or surgical treatment has been provided by the Plan for the condition resulting in the scar;

76) Skin tags;
77) Smoking Cessation Those services and supplies for smoking cessation programs and treatment of nicotine addiction;

78) Speech Therapy - Health Services for the diagnosis and treatment of chronic brain injury, including augmentative communication devices, developmental delay, mental retardation or cerebral palsy are not Covered, except as provided in Section 6 (Covered Services) or attached Rider;

79) Sports Related Services – Those services or devices used specifically as safety items or to affect performance primarily in sports-related activities, and all expenses related to physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation; personal trainers; braces and Orthotics (including protective braces and devices);

80) Sterilization Services – Those Health Services and associated expenses related to voluntary sterilizations and the reversal of voluntary sterilizations;

81) Surgery performed solely to address psychological or emotional factors;

82) Surrogate motherhood services and supplies, including, but not limited to, all services and supplies relating to the conception and pregnancy of a Member acting as a surrogate mother;

83) Syringes - Disposable syringes (except for insulin syringes);

84) Third Party Liability - Services for which a third party has liability are excluded, including services Covered by federal, state, and other laws, except as they may apply to federal and state medical assistance programs;

85) Transplant Organ Removal – Those Health Services and associated expenses for removal of an organ for the purposes of transplantation from a donor who is not a Member unless the recipient is a Member and the donor’s medical Coverage excludes reimbursement for organ harvesting. Also excluded are Health Services and associated expenses for transplants involving mechanical or animal organs;

86) Transplant services, screening tests, and any related conditions or complications related to organ donation when a Member is donating organ or tissue to a non-Covered individual;

87) Travel Expenses - Travel or transportation expenses, except ambulance service as specifically described in this Plan, even though prescribed by a Participating Provider, except as specified in Section 6;

88) Treatment for disorders relating to learning, motor skills, communication, and pervasive developmental conditions such as, cerebral palsy and ADD;

89) Vericose Veins;

90) Vision Aids, Associated Services Expenses incurred for eyeglasses, lenses or frames; fitting of lenses or frames; orthoptics or vision training; biomicroscopy; field charting or aniseikonia investigation; devices to correct
vision; LASIK, radial keratotomy low vision aids and services or other refractive surgery; any service or material not provided by the Plan’s Designated Vision Provider, except as provided in a Vision Rider;

92) Vision care and optometry services, except as provided in Section 6;

93) Vocational therapy;

94) War related Illness, Injury, services or care for military services-connected disabilities and conditions for which You are legally entitled to Veteran’s Administration services and for which facilities are reasonably accessible to You;

95) Health Services resulting from war or an act of war;

96) Work hardening programs;

97) Workers' Compensation Health Services - Payment for services or supplies for an Illness or Injury eligible for, or Covered by, any Federal, State or local Government Workers’ Compensation Act, Occupational Disease law or other legislation of similar purpose, unless the employer is not required by law to provide such coverage;

The following limitations apply:

98) Any services, Hospital, professional or otherwise that are not performed by a Participating Provider will be covered at the Out-of-Network benefit level. This limitation shall not apply for Medical Emergencies or Urgent Care Services rendered at an urgent care center or after hour’s facility. In the event that specific Health Services cannot be provided by or through a Participating Provider, You may be eligible for Coverage of Eligible Expenses at the In-Network level for Medically Necessary Health Services obtained through non-Participating Providers if Authorized in advance through the Plan.

99) Benefits will be reduced as follows when a Member does not participate in our Utilization Management Program:

If a Member elects not to request Prior Authorization and Continued Stay Review for inpatient Hospital services or fails to act within the required time limits, a $1,000 penalty will be assessed. Any penalty is not applicable to the Out-of-Pocket Maximum.

If other services which require Prior Authorization as stipulated in Section 2.3 are performed without a Prior Authorization, Coverage of those Covered Services will be reduced by 20%, subject to any applicable Deductible and Coinsurance. Any payment due to a reduction of benefits does not apply to the Out-of-Pocket Maximum. Any Deductible will be applied prior to a reduction in benefits.