Your Guide to Individual and Family Health Benefit Policies

Kansas

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Summary of Benefits for Plan Code – KI10C05020 25
KIGOC05020 25
$500 Deductible, 80/50% Coinsurance, $25/50 Office Visit

Benefits	Member pays	
	In-network	Out-of-network
Annual Deductible	$500 Individual $1,500 Family	$1,000 Individual $3,000 Family
Out of pocket maximum (coinsurance only applies toward this maximum)	$2,000 Individual $6,000 Family	$4,000 Individual $12,000 Family
Maximum lifetime benefits	$2,000,000	
Prescription drugs (Outpatient) up to a 31-day supply **KI10C05020 25** -Four Tier Plan **KIGOC05020 25**-Preferred Generic Only	Participating Retail Pharmacy: $10/$45/$75/30% ✧ $12 copayment (✧ See Rider document)	See Rider document See Rider document
Physician services *If provided by a Primary Care provider then Primary Care copayment applies. If provided by Specialist then Specialist copayment applies.		
Office visit and related services (including surgery performed in the office)		
Primary Care	$25 copayment	Deductible + 50% coinsurance
Specialist	$50 copayment	Deductible + 50% coinsurance
Preventive care ($300/year limit)		
Well child visits	*Office visit copayment	Deductible + 50% coinsurance
Mammograms	No copayment	Deductible + 50% coinsurance
Immunizations (birth up to 72 months of age)	No copayment	No copayment
Allergy Testing	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Spinal Manipulations	$35 copayment	Deductible + 50% coinsurance
Inpatient hospital services (including physician, facility and surgery charges)	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Outpatient surgery and scopes	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Outpatient laboratory services	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Outpatient diagnostic testing	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Other outpatient services	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Urgent care services	$50 copayment	Same as In-network
Emergency care services		
Emergency room facility (copayment waived if admitted)	Deductible + 20% coinsurance	Same as In-network
Emergency room physician fees	20% coinsurance	Same as In-network
Ambulance (ground or air, when medically necessary)	Deductible + 20% coinsurance	Same as In-network
Short-term therapies (physical, speech, occupational – limited to 20 visits per therapy per Calendar Year Benefit Maximum)	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Skilled nursing facility services (limited to 60 days per Calendar Year)	Same as Inpatient benefit	Deductible + 50% coinsurance
Home health care	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Hospice (Inpatient limited to 15 days per Calendar Year)	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Durable medical equipment (limited to $3,000 per Calendar Year)	50% coinsurance	Deductible + 50% coinsurance
Prosthetics & Braces (limited to $3,000 per Calendar Year)	50% coinsurance	Deductible + 50% coinsurance
Mental health, substance abuse services	See Page 19	

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Summary of Benefits for Plan Code(s) – KI10C10025 25
KIGOC10025 25

$1,000 Deductible, 80/50% Coinsurance, $25/50 Office Visit

Benefits	Member pays	
	In-network	Out-of-network
Annual Deductible	$1,000 Individual $3,000 Family	$2,000 Individual $6,000 Family
Out of pocket maximum (coinsurance only applies toward this maximum)	$2,500 Individual $7,500 Family	$5,000 Individual $15,000 Family
Maximum lifetime benefits	$2,000,000	
Prescription drugs (Outpatient) up to a 31-day supply		
KI10C10025 25-Four Tier Plan	Participating Retail Pharmacy: $10/$45/$75/30% ✧	See Rider document
KIGOC10025 25-Preferred Generic Only	$12 copayment	See Rider document
	(✧ See Rider document)	
Physician services *If provided by a Primary Care provider then Primary Care copayment applies. If provided by Specialist then Specialist copayment applies.		
Office visit and related services (including surgery performed in the office)		
Primary Care	$25 copayment	Deductible + 50% coinsurance
Specialist	$50 copayment	Deductible + 50% coinsurance
Preventive care ($300/year limit)		
Well child visits	*Office visit copayment	Deductible + 50% coinsurance
Mammograms	No copayment	Deductible + 50% coinsurance
Immunizations (birth up to 72 months of age)	No copayment	No copayment
Allergy Testing	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Spinal Manipulations	$35 copayment	Deductible + 50% coinsurance
Inpatient hospital services (including physician, facility and surgery charges)	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Outpatient surgery and scopes	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Outpatient laboratory services	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Outpatient diagnostic testing	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Other outpatient services	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Urgent care services	$50 copayment	Same as In-network
Emergency care services		
Emergency room facility (copayment waived if admitted)	Deductible + 20% coinsurance	Same as In-network
Emergency room physician fees	20% coinsurance	Same as In-network
Ambulance (ground or air, when medically necessary)	Deductible + 20% coinsurance	Same as In-network
Short-term therapies (physical, speech, occupational – limited to 20 visits per therapy per Calendar Year Benefit Maximum)	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Skilled nursing facility services (limited to 60 days per Calendar Year)	Same as Inpatient benefit	Deductible + 50% coinsurance
Home health care	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Hospice (Inpatient limited to 15 days per Calendar Year)	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Durable medical equipment (limited to $3,000 per Calendar Year)	50% coinsurance	Deductible + 50% coinsurance
Prosthetics & Braces (limited to $3,000 per Calendar Year)	50% coinsurance	Deductible + 50% coinsurance
Mental health, substance abuse services	See Page 19	

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Summary of Benefits for Plan Code – KI10C20040 30
KIGOC20040 30
$2,000 Deductible, 80/50% Coinsurance, $30/60 Office Visit

Benefits	Member pays	
	In-network	Out-of-network
Annual Deductible	$2,000 Individual $6,000 Family	$4,000 Individual $12,000 Family
Out of pocket maximum (coinsurance only applies toward this maximum)	$4,000 Individual $12,000 Family	$8,000 Individual $24,000 Family
Maximum lifetime benefits	$2,000,000	
Prescription drugs (Outpatient) up to a 31-day supply **KI10C20040 30-**Four Tier Plan **KIGOC20040 30-**Preferred Generic Only	Participating Retail Pharmacy: $10/$45/$75/30% ✧ $12 copayment (✧ See Rider document)	 See Rider document See Rider document
Physician services *If provided by a Primary Care provider then Primary Care copayment applies. If provided by Specialist then Specialist copayment applies.		
Office visit and related services (including surgery performed in the office) **Primary Care** **Specialist** **Preventive care** ($300/year limit) **Well child visits** **Mammograms** **Immunizations** (birth up to 72 months of age) **Allergy Testing** **Spinal Manipulations**	 $30 copayment $60 copayment *Office visit copayment No copayment No copayment Deductible + 20% coinsurance $35 copayment	 Deductible + 50% coinsurance Deductible + 50% coinsurance Deductible + 50% coinsurance Deductible + 50% coinsurance No copayment Deductible + 50% coinsurance Deductible + 50% coinsurance
Inpatient hospital services (including physician, facility and surgery charges)	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Outpatient surgery and scopes **Outpatient laboratory services** **Outpatient diagnostic testing** **Other outpatient services**	Deductible + 20% coinsurance Deductible + 20% coinsurance Deductible + 20% coinsurance Deductible + 20% coinsurance	Deductible + 50% coinsurance Deductible + 50% coinsurance Deductible + 50% coinsurance Deductible + 50% coinsurance
Urgent care services	$60 copayment	Same as In-network
Emergency care services **Emergency room facility** (copayment waived if admitted) **Emergency room physician fees** **Ambulance** (ground or air, when medically necessary)	 Deductible + 20% coinsurance 20% coinsurance Deductible + 20% coinsurance	 Same as In-network Same as In-network Same as In-network
Short-term therapies (physical, speech, occupational – limited to 20 visits per therapy per Calendar Year Benefit Maximum)	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Skilled nursing facility services (limited to 60 days per Calendar Year)	Same as Inpatient benefit	Deductible + 50% coinsurance
Home health care	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Hospice (Inpatient limited to 15 days per Calendar Year)	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Durable medical equipment (limited to $3,000 per Calendar Year)	50% coinsurance	Deductible + 50% coinsurance
Prosthetics & Braces (limited to $3,000 per Calendar Year)	50% coinsurance	Deductible + 50% coinsurance
Mental health, substance abuse services	See Page 19	

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Summary of Benefits for Plan Code – KI10C25045 30
KIGOC25045 30

$2,500 Deductible, 80/50% Coinsurance, $30/60 Office Visit

Benefits	Member pays	
	In-network	Out-of-network
Annual Deductible	$2,500 Individual $7,500 Family	$5,000 Individual $15,00 Family
Out of pocket maximum (coinsurance only applies toward this maximum)	$4,500 Individual $13,500 Family	$9,000 Individual $27,000 Family
Maximum lifetime benefits	$2,000,000	
Prescription drugs (Outpatient) up to a 31-day supply **KI10C25045 30-**Four Tier Plan **KIGOC25045 30-**Preferred Generic Only	Participating Retail Pharmacy: $10/$45/$75/30% ✧ $12 copayment (✧ See Rider document)	See Rider Document See Rider Document
Physician services *If provided by a Primary Care provider then Primary Care copayment applies. If provided by Specialist then Specialist copayment applies.		
Office visit and related services (including surgery performed in the office)		
Primary Care	$30 copayment	Deductible + 50% coinsurance
Specialist	$60 copayment	Deductible + 50% coinsurance
Preventive care ($300/year limit)		
Well child visits	*Office visit copayment	Deductible + 50% coinsurance
Mammograms	No copayment	Deductible + 50% coinsurance
Immunizations (birth up to 72 months of age)	No copayment	No copayment
Allergy Testing	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Spinal Manipulations	$35 copayment	Deductible + 50% coinsurance
Inpatient hospital services (including physician, facility and surgery charges)	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Outpatient surgery and scopes	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Outpatient laboratory services	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Outpatient diagnostic testing	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Other outpatient services	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Urgent care services	$60 copayment	Same as In-network
Emergency care services		
Emergency room facility (copayment waived if admitted)	Deductible + 20% coinsurance	Same as In-network
Emergency room physician fees	20% coinsurance	Same as In-network
Ambulance (ground or air, when medically necessary)	Deductible + 20% coinsurance	Same as In-network
Short-term therapies (physical, speech, occupational – limited to 20 visits per therapy per Calendar Year Benefit Maximum)	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Skilled nursing facility services (limited to 60 days per Calendar Year)	Same as Inpatient benefit	Deductible + 50% coinsurance
Home health care	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Hospice (Inpatient limited to 15 days per Calendar Year)	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Durable medical equipment (limited to $3,000 per Calendar Year)	50% coinsurance	Deductible + 50% coinsurance
Prosthetics & Braces (limited to $3,000 per Calendar Year)	50% coinsurance	Deductible + 50% coinsurance
Mental health, substance abuse services	See Page 19	

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Summary of Benefits for Plan Code – KI10C30050 35
KIGOC30050 35

$3,000 Deductible, 80/50% Coinsurance, $35/70 Office Visit

Benefits	Member pays	
	In-network	Out-of-network
Annual Deductible	$3,000 Individual $9,000 Family	$6,000 Individual $18,000 Family
Out of pocket maximum (coinsurance only applies toward this maximum)	$5,000 Individual $15,000 Family	$10,000 Individual $30,000 Family
Maximum lifetime benefits	$2,000,000	
Prescription drugs (Outpatient) up to a 31-day supply **KI10C30050 35-**Four Tier Plan **KIGOC30050 35-**Preferred Generic Only	Participating Retail Pharmacy: $10/$45/$75/30% ✧ $12 copayment (✧ See Rider document)	 See Rider document See Rider document
Physician services *If provided by a Primary Care provider then Primary Care copayment applies. If provided by Specialist then Specialist copayment applies.		
Office visit and related services (including surgery performed in the office) **Primary Care** **Specialist**	 $35 copayment $70 copayment	 Deductible + 50% coinsurance Deductible + 50% coinsurance
Preventive care ($300/year limit) **Well child visits** **Mammograms** **Immunizations** (birth up to 72 months of age)	 *Office visit copayment No copayment No copayment	 Deductible + 50% coinsurance Deductible + 50% coinsurance No copayment
Allergy Testing **Spinal Manipulations**	Deductible + 20% coinsurance $35 copayment	Deductible + 50% coinsurance Deductible + 50% coinsurance
Inpatient hospital services (including physician, facility and surgery charges)	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Outpatient surgery and scopes **Outpatient laboratory services** **Outpatient diagnostic testing** **Other outpatient services**	Deductible + 20% coinsurance Deductible + 20% coinsurance Deductible + 20% coinsurance Deductible + 20% coinsurance	Deductible + 50% coinsurance Deductible + 50% coinsurance Deductible + 50% coinsurance Deductible + 50% coinsurance
Urgent care services	$70 copayment	Same as In-network
Emergency care services **Emergency room facility** (copayment waived if admitted) **Emergency room physician fees** **Ambulance** (ground or air, when medically necessary)	 Deductible + 20% coinsurance 20% coinsurance Deductible + 20% coinsurance	 Same as In-network Same as In-network Same as In-network
Short-term therapies (physical, speech, occupational – limited to 20 visits per therapy per Calendar Year Benefit Maximum)	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Skilled nursing facility services (limited to 60 days per Calendar Year)	Same as Inpatient benefit	Deductible + 50% coinsurance
Home health care	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Hospice (Inpatient limited to 15 days per Calendar Year)	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Durable medical equipment (limited to $3,000 per Calendar Year)	50% coinsurance	Deductible + 50% coinsurance
Prosthetics & Braces (limited to $3,000 per Calendar Year)	50% coinsurance	Deductible + 50% coinsurance
Mental health, substance abuse services	See Page 19	

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Summary of Benefits for Plan Code – KI10C50065 40
KIGOC50065 40

$5,000 Deductible, 80/50% Coinsurance, $40/80 Office Visit

Benefits	Member pays	
	In-network	Out-of-network
Annual Deductible	$5,000 Individual $10,000 Family	$10,000 Individual $20,000 Family
Out of pocket maximum (coinsurance only applies toward this maximum)	$6,500 Individual $13,000 Family	$13,000 Individual $26,000 Family
Maximum lifetime benefits	$2,000,000	
Prescription drugs (Outpatient) up to a 31-day supply		
KI10C50065 40-Four Tier Plan	Participating Retail Pharmacy: $10/$45/$75/30% ✧	See Rider document
KIGO50065 40-Preferred Generic Only	$12 copayment	See Rider document
	(✧ See Rider document)	
Physician services *If provided by a Primary Care provider then Primary Care copayment applies. If provided by Specialist then Specialist copayment applies.		
Office visit and related services (including surgery performed in the office)		
Primary Care	$40 copayment	Deductible + 50% coinsurance
Specialist	$80 copayment	Deductible + 50% coinsurance
Preventive care ($300/year limit)		
Well child visits	*Office visit copayment	Deductible + 50% coinsurance
Mammograms	No copayment	Deductible + 50% coinsurance
Immunizations (birth up to 72 months of age)	No copayment	No copayment
Allergy Testing	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Spinal Manipulations	$35 copayment	Deductible + 50% coinsurance
Inpatient hospital services (including physician, facility and surgery charges)	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Outpatient surgery and scopes	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Outpatient laboratory services	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Outpatient diagnostic testing	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Other outpatient services	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Urgent care services	$80 copayment	Same as In-network
Emergency care services		
Emergency room facility (copayment waived if admitted)	Deductible + 20% coinsurance	Same as In-network
Emergency room physician fees	20% coinsurance	Same as In-network
Ambulance (ground or air, when medically necessary)	Deductible + 20% coinsurance	Same as In-network
Short-term therapies (physical, speech, occupational – limited to 20 visits per therapy per Calendar Year Benefit Maximum)	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Skilled nursing facility services (limited to 60 days per Calendar Year)	Same as Inpatient benefit	Deductible + 50% coinsurance
Home health care	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Hospice (Inpatient limited to 15 days per Calendar Year)	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Durable medical equipment (limited to $3,000 per Calendar Year)	50% coinsurance	Deductible + 50% coinsurance
Prosthetics & Braces (limited to $3,000 per Calendar Year)	50% coinsurance	Deductible + 50% coinsurance
Mental health, substance abuse services	See Page 19	

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Summary of Benefits for Plan Code – KI10C75090 50
KIGOC75090 50
$7,500 Deductible, 80/50% Coinsurance, $50/100 Office Visit

Benefits	Member pays	
	In-network	Out-of-network
Annual Deductible	$7,500 Individual $15,000 Family	$5,000 Individual $30,000 Family
Out of pocket maximum (coinsurance only applies toward this maximum)	$9,000 Individual $18,000 Family	$18,000 Individual $36,000 Family
Maximum lifetime benefits	$2,000,000	
Prescription drugs (Outpatient) up to a 31-day supply		
KI10C75090 50-Four Tier Plan	Participating Retail Pharmacy: $10/$45/$75/30% ✧	See Rider document
KIGOC75090 50-Preferred Generic Only	$12 copayment	See Rider document
	(✧ See Rider document)	
Physician services *If provided by a Primary Care provider then Primary Care copayment applies. If provided by Specialist then Specialist copayment applies.		
Office visit and related services (including surgery performed in the office)		
Primary Care	$50 copayment	Deductible + 50% coinsurance
Specialist	$100 copayment	Deductible + 50% coinsurance
Preventive care ($300/year limit)		
Well child visits	*Office visit copayment	Deductible + 50% coinsurance
Mammograms	No copayment	Deductible + 50% coinsurance
Immunizations (birth up to 72 months of age)	No copayment	No copayment
Allergy Testing	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Spinal Manipulations	$35 copayment	Deductible + 50% coinsurance
Inpatient hospital services (including physician, facility and surgery charges)	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Outpatient surgery and scopes	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Outpatient laboratory services	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Outpatient diagnostic testing	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Other outpatient services	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Urgent care services	$100 Copayment	Same as In-network
Emergency care services		
Emergency room facility (copayment waived if admitted)	Deductible + 20% coinsurance	Same as In-network
Emergency room physician fees	20% coinsurance	Same as In-network
Ambulance (ground or air, when medically necessary)	Deductible + 20% coinsurance	Same as In-network
Short-term therapies (physical, speech, occupational – limited to 20 visits per therapy per Calendar Year Benefit Maximum)	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Skilled nursing facility services (limited to 60 days per Calendar Year)	Same as Inpatient benefit	Deductible + 50% coinsurance
Home health care	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Hospice (Inpatient limited to 15 days per Calendar Year)	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Durable medical equipment (limited to $3,000 per Calendar Year)	50% coinsurance	Deductible + 50% coinsurance
Prosthetics & Braces (limited to $3,000 per Calendar Year)	50% coinsurance	Deductible + 50% coinsurance
Mental health, substance abuse services	See Page 19	

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Summary of Benefits for Plan Code – KI10C1000150 50
KIGOC1000150 50

$10,000 Deductible, 80/50% Coinsurance, $50/100 Office Visit

Benefits	Member pays	
	In-network	Out-of-network
Annual Deductible	$10,000 Individual $20,000 Family	$20,000 Individual $40,000 Family
Out of pocket maximum (coinsurance only applies toward this maximum)	$15,000 Individual $30,000 Family	$30,000 Individual $60,000 Family
Maximum lifetime benefits	$2,000,000	
Prescription drugs (Outpatient) up to a 31-day supply **KI10C1000150 50-**Four Tier Plan **KIGOC1000150 50-**Preferred Generic Only	Participating Retail Pharmacy: $10/$45/$75/30% ✧ $12 copayment (✧ See Rider document)	See Rider document See Rider document
Physician services *If provided by a Primary Care provider then Primary Care copayment applies. If provided by Specialist then Specialist copayment applies.		
Office visit and related services (including surgery performed in the office)		
Primary Care	$50 copayment	Deductible + 50% coinsurance
Specialist	$100 copayment	Deductible + 50% coinsurance
Preventive care ($300/year limit)		
Well child visits	*Office visit copayment	Deductible + 50% coinsurance
Mammograms	No copayment	Deductible + 50% coinsurance
Immunizations (birth up to 72 months of age)	No copayment	No copayment
Allergy Testing	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Spinal Manipulations	$35 copayment	Deductible + 50% coinsurance
Inpatient hospital services (including physician, facility and surgery charges)	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Outpatient surgery and scopes	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Outpatient laboratory services	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Outpatient diagnostic testing	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Other outpatient services	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Urgent care services	$100 copayment	Same as In-network
Emergency care services		
Emergency room facility (copayment waived if admitted)	Deductible + 20% coinsurance	Same as In-network
Emergency room physician fees	50% coinsurance	Same as In-network
Ambulance (ground or air, when medically necessary)	Deductible + 20% coinsurance	Same as In-network
Short-term therapies (physical, speech, occupational – limited to 20 visits per therapy per Calendar Year Benefit Maximum)	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Skilled nursing facility services (limited to 60 days per Calendar Year)	Same as Inpatient benefit	Deductible + 50% coinsurance
Home health care	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Hospice (Inpatient limited to 15 days per Calendar Year)	Deductible + 20% coinsurance	Deductible + 50% coinsurance
Durable medical equipment (limited to $3,000 per Calendar Year)	50% coinsurance	Deductible + 50% coinsurance
Prosthetics & Braces (limited to $3,000 per Calendar Year)	50% coinsurance	Deductible + 50% coinsurance
Mental health, substance abuse services	See Page 19	

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Qualified High Deductible Health Plans

Benefit Summaries
for
KANSAS
Individuals

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PPO

Summary of Benefits for Plan Code – KI10QA25025 30 (Qualified HDHP)
Deductible + 0% Coinsurance, $2,500 Deductible, 0/20% Coinsurance

Benefits	Member pays	
	In-network	Out-of-network
Annual Calendar Year Deductible *	$2,500 Individual $5,000 Family	$2,500 Individual $5,000 Family
Out of pocket maximum	$2,500 Individual or $5,000 Family	$5,000 Individual or $10,000 Family
Maximum lifetime benefits	$2,000,000	
Physician services **Office visit and related services** (including surgery performed in the office) **Preventive care** ($300/year limit) **Well child visits** **Mammograms** **Immunizations** (birth up to 72 months of age)	Deductible + 0% coinsurance $30 copayment No copayment No copayment	Deductible + 20% coinsurance Deductible + 20% coinsurance Deductible + 20% coinsurance No copayment
Inpatient hospital services (including physician, facility and surgery charges)	Deductible + 0% coinsurance	Deductible + 20% coinsurance
Outpatient surgery and scopes **Outpatient laboratory services** **Outpatient diagnostic testing** **Other outpatient services**	Deductible + 0% coinsurance Deductible + 0% coinsurance Deductible + 0% coinsurance Deductible + 0% coinsurance	Deductible + 20% coinsurance Deductible + 20% coinsurance Deductible + 20% coinsurance Deductible + 20% coinsurance
Urgent care services	Deductible + 0% coinsurance	Deductible + 0% coinsurance
Emergency care services **Emergency room facility** **Emergency room physician fees** **Ambulance** (ground or air, when medically necessary)	 Deductible + 0% coinsurance Deductible + 0% coinsurance Deductible + 0% coinsurance	 Deductible + 0% coinsurance Deductible + 0% coinsurance Deductible + 0% coinsurance
Short-term therapies (physical, speech, occupational – limited to 20 visits per therapy per Calendar Year Benefit Maximum)	Deductible + 0% coinsurance	Deductible + 20% coinsurance
Skilled nursing facility services (limited to 60 days per Calendar Year)	Deductible + 0% coinsurance	Deductible + 20% coinsurance
Home health care	Deductible + 0% coinsurance	Deductible + 20% coinsurance
Hospice	Deductible + 0% coinsurance	Deductible + 20% coinsurance
Durable medical equipment (limited to $3,000 per Calendar Year)	Deductible + 0% coinsurance	Deductible + 20% coinsurance
Prosthetics & Braces (limited to $3,000 per Calendar Year)	Deductible + 0% coinsurance	Deductible + 20% coinsurance
Outpatient prescription drugs up to a 31-day supply	Participating Retail Pharmacy: Deductible + 0% coinsurance	See Rider document for details
Mental health, substance abuse services	See Page 19	

* If you have individual-only coverage, you must satisfy the individual deductible and/or out of pocket maximum before any benefits will be paid. If two or more family members are on the same policy, you must satisfy the family deductible and/or out of pocket maximum before any benefits will be paid.

This summary is a partial description of the Coventry*One* Policy underwritten by Coventry Health and Life Insurance Company, and in no way details all of the benefits, limitations, or exclusions of the plan. Please refer to the Individual Policy, Schedule of Benefits and applicable Riders to determine exact terms, conditions and scope of coverage, including all exclusions and limitations and defined terms.

CoventryOne.

PPO

Summary of Benefits for Plan Code – KI10QA50050 20 (Qualified HDHP)
Deductible + 0% Coinsurance, $5,000 Deductible, 0/20% Coinsurance

Benefits	Member pays	
	In-network	Out-of-network
Annual Calendar Year Deductible *	$5,000 Individual $10,000 Family	$5,000 Individual $10,000 Family
Out of pocket maximum	$5,000 Individual or $10,000 Family	$10,000 Individual or $20,000 Family
Maximum lifetime benefits	$2,000,000	
Physician services **Office visit and related services** (including surgery performed in the office) **Preventive care** ($300/year limit) **Well child visits** **Mammograms** **Immunizations** (birth up to 72 months of age)	Deductible + 0% coinsurance $20 copayment No copayment No copayment	Deductible + 20% coinsurance Deductible + 20% coinsurance Deductible + 20% coinsurance No copayment
Inpatient hospital services (including physician, facility and surgery charges)	Deductible + 0% coinsurance	Deductible + 20% coinsurance
Outpatient surgery and scopes **Outpatient laboratory services** **Outpatient diagnostic testing** **Other outpatient services**	Deductible + 0% coinsurance Deductible + 0% coinsurance Deductible + 0% coinsurance Deductible + 0% coinsurance	Deductible + 20% coinsurance Deductible + 20% coinsurance Deductible + 20% coinsurance Deductible + 20% coinsurance
Urgent care services	Deductible + 0% coinsurance	
Emergency care services **Emergency room facility** **Emergency room physician fees** **Ambulance** (ground or air, when medically necessary)	 Deductible + 0% coinsurance Deductible + 0% coinsurance Deductible + 0% coinsurance	 Deductible + 0% coinsurance Deductible + 0% coinsurance Deductible + 0% coinsurance
Short-term therapies (physical, speech, occupational – limited to 20 visits per therapy per Calendar Year Benefit Maximum)	Deductible + 0% coinsurance	Deductible + 20% coinsurance
Skilled nursing facility services (limited to 60 days per Calendar Year)	Deductible + 0% coinsurance	Deductible + 20% coinsurance
Home health care	Deductible + 0% coinsurance	Deductible + 20% coinsurance
Hospice	Deductible + 0% coinsurance	Deductible + 20% coinsurance
Durable medical equipment (limited to $3,000 per Calendar Year)	Deductible + 0% coinsurance	Deductible + 20% coinsurance
Prosthetics & Braces (limited to $3,000 per Calendar Year)	Deductible + 0% coinsurance	Deductible + 20% coinsurance
Outpatient prescription drugs up to a 31-day supply	Participating Retail Pharmacy: Deductible + 0% coinsurance	See Rider document for details
Mental health, substance abuse services	See Page 19	

* If you have individual-only coverage, you must satisfy the individual deductible and/or out of pocket maximum before any benefits will be paid. If two or more family members are on the same policy, you must satisfy the family deductible and/or out of pocket maximum before any benefits will be paid.

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Mental Health and Substance Abuse Services

Note: Mental Health and Substance Abuse benefits are subject to Kansas mandates. For more information regarding any limitation, exclusions or defined terms, please ask for a copy of the Mental Health Rider and the Coventry*One* Policy.

Covered Services are as follows:

Mental Illnesses Benefits

- Inpatient treatment subject to the Hospital Inpatient Deductible, Copayment and/or Coinsurance as listed in the Benefit Summary. Limited to forty-five (45) days per Calendar Year.
- Outpatient treatment is subject to the Specialty Physician Deductible, Copayment and/or Coinsurance as listed in the Benefit Summary.

Chemical Dependency Benefits

- Inpatient treatment subject to the Hospital Inpatient Deductible, Copayment and/or Coinsurance as listed in the Benefit Summary. Limited to thirty (30) days per Calendar Year.
- Outpatient treatment is subject to the Specialty Physician Deductible, Copayment and/or Coinsurance as listed in the Benefit Summary.

Exclusions and Limitations

Pre-Existing Conditions Limitation

A Pre-Existing Condition is any condition for which You received medical advice, diagnosis, care, treatment or recommended treatment from an individual licensed or similarly authorized to provide such services under applicable state law within the twelve (12) month period prior to the effective date of your Coverage. A condition may be defined as Pre-Existing whether physical or mental, and regardless of the cause of the condition. Genetic information shall not be treated as a pre-existing condition in the absence of a diagnosis of the condition relating to such information.

Pre-Existing Conditions may affect Your premium rate, may result in denial of Your application, or We may deny Coverage for them for a period of time after Your effective date. If You are accepted for Coverage, Your premium rate will be calculated to include any Pre-Existing Condition that You disclosed on Your enrollment form, and such conditions will be Covered under the terms of Your Policy beginning on Your effective date. **Any Pre-Existing Condition(s) that is not disclosed on Your enrollment form will be excluded from Coverage for a period not longer than twelve (12) months after Your effective date. Any information that is omitted or misrepresented could provide the basis to refuse or rescind (cancel) coverage.**

Non-Duplication of Coverage Under Certain Laws

This Policy will always be secondary to any state no-fault law that requires motor vehicle liability policies to provide personal injury protection insurance for the insured and any passengers. Individual automobile "no fault" medical payment contracts that provide personal injury protection or no-fault benefits in excess of the minimum limits required by state law will remain primary to the limit or extent of the personal injury protection benefit provided in the automobile insurance policy. The plan benefits will be reduced by the amount of the personal injury protection coverage paid for by any such no-fault law or limit provided in the applicable automobile insurance policy. If a vehicle insurance policy has a provision providing personal injury protection coverage, whether required by law or not, such coverage will be primary over coverage provided by this Policy. The Insured agrees to furnish information to the Plan concerning any applicable personal injury protection insurance upon request.

Right of Recovery

The Plan has the right to correct benefit payments that are made in error. Providers and/or You have the responsibility to return any overpayments to the Plan. The Plan has the responsibility to make additional payments if any underpayments have been made

General Exclusions

Unless otherwise stated in the Coventry*One* Policy or any applicable Riders attached to the Policy, the following items are excluded from Coverage. For more information regarding any terms used in the exclusions presented below, please see Section 1, the Defined Terms of the Coventry*One* Policy. Unless otherwise stated in this Policy, the following items are excluded from Coverage:

- Any service or supply that is provided by a Provider **not** in accordance with the Plan's utilization management policies and procedures, except that Emergency Services shall be Covered in accordance with the terms and conditions set forth in this Policy;
- Any service or supply that is not Medically Necessary;
- Any service or supply that is not a Covered Service or that is directly or indirectly a result of receiving a non-Covered Service;
- Any service or supply for which You have no financial liability or that was provided at no charge; those services for which the Insured has no legal obligation to pay or for which a charge would not ordinarily be made in the absence of Coverage under the Policy;
- Procedures and treatments that the Plan determines and defines to be Experimental or Investigational;
- Court-ordered services or services that are a condition of probation or parole;
- Those services otherwise Covered under the Policy, but rendered after the date Coverage under the Policy terminates, including services for medical conditions arising prior to the date individual Coverage under the Policy terminates; and
- Those services rendered outside the scope of a Participating or Non-Participating Provider's license, rendered by a Provider with the same legal residence as the Insured, or rendered by a person who is a member of the Insured's family, including Spouse, brother, sister, parent, step-parent, child or step-child.

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

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

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;

Alternative Therapies - Alternative therapies including, but not limited to, aquatic, recreational, wilderness, educational, music or sleep therapies and any related diagnostic testing;

Ambulance Service - Non-Emergency and non-medically appropriate ambulance services are excluded regardless of who requested the services, including ambulance transport due to the absence of other transportation for the Insured;

Augmentative Communication Devices – Devices including but not limited to, those used to assist hearing impaired, or physically or developmentally disabled Insureds;

Autopsy - Those services and associated expenses related to the performance of autopsies, and also post-mortem genetic studies;

Behavior modification;

Biofeedback;

Blood and Blood Products - The cost of whole blood and blood products replacement to a blood bank;

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;

Braces and supports needed for athletic participation or employment;

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

Cochlear Implants and related services;

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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 done for augmentation or for cosmetic purposes;

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

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;

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;

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.

Removal of teeth, including any prophylactic extractions, as a complication of radionecrosis is not a Covered Service

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.;

Medical services and expenses incurred for learning disabilities, developmental delays, mental retardation, and autistic disorders.

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 oximetry units; 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;

Educational Services Those educational 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;

Equipment or services for use in altering air quality or temperature;

Educational testing or psychological testing, unless part of a treatment program for Covered Services;

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 Plan;

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

Enteral Feeding Food Supplement - The cost of outpatient enteral tube feedings or formula and supplies except when used for PKU or any other amino and organic acid inherited disease is not Covered, except as defined as a Covered Service, regardless of whether it is the sole source of nutrition except as provided under for PKU, Amino or Organic Acid Inherited Disease for food or formula;

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;

Exercise equipment, hot tubs and pools;

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;

Food or food supplements regardless of whether it is the sole source of nutrition except as provided under for PKU, Amino or Organic Acid Inherited Disease;

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;

Foreign Travel - care, treatment or supplies received outside of the U.S. if travel is primarily for the purpose of obtaining medical services;

Growth Hormone – Growth hormone therapy for any condition, except in children less than 18 years of age who have been appropriately diagnosed to have an actual growth hormone deficiency according to clinical guidelines used by the Plan;

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;

Home services to help meet personal, family, or domestic needs;

Health and Athletic Club Membership - Any costs of enrollment in a health, athletic or similar club;

Hearing Services and Supplies - Those services and associated expenses for hearing aids, cochlear implants, digital and programmable hearing devices, the examination for prescribing and fitting hearing aids, hearing therapy and any related diagnostic hearing tests;

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, hypo-allergenic pillows, power assist chairs, mattresses or waterbeds and electronic communication devices;

Hypnotherapy and Hypnosis;

Immunizations unless specifically covered under the Policy, including but not limited to immunizations required for travel, school, work-related, Anthrax vaccine and Lyme Disease vaccine. Also excluded are examinations and testing in connection with insurance, obtaining employment, specifically for the purpose of entering school, participating in extracurricular school activities, adoption, immigration and naturalization, or examinations or treatment ordered by a court or an employer; premarital blood testing;

Infertility/Assisted Reproductive Services - Those non-diagnostic services and associated expenses 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, 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, 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;

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;

Maternity Services – Expenses incurred for any condition of or related to pregnancy, unless specifically covered in the Schedule of Benefits. Also excluded are expenses associated with selective reduction during pregnancy.

Maintenance Therapy – Once the maximum therapeutic benefit has been achieved for a given condition, ongoing Maintenance Therapy is not considered Medically Necessary;

Male Gynecomastia – Those services and associated expenses for treatment of male gynecomastia.

Massage Therapy – Those services and associated expenses related to massage therapy;

Medical complications arising directly or indirectly from a non-Covered Service;

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 Insured who is on active military duty except as required by the Uniformed Services Employment and Reemployment Rights Act; or 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;

Miscellaneous Service Charges - Telephone consultations, document processing or copying fees, mailing costs, charges for completion of forms, charges for failure to keep a scheduled appointment (unless the scheduled appointment was for a Mental Health service), any late payment charge, interest charges or other non-medical charges;

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;

Nutritional-based Therapy - Nutritional-based therapies except for treatment of 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 regardless of whether it is the sole source of nutrition except as provided under for PKU, Amino or Organic Acid Inherited Disease for food or formula;

Newborn home delivery and also the cost of child birth classes;

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;

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 benefit, medical benefits that would have been compensable except for the settlement will not be Covered Services under this Policy;

Oral Surgery Supplies - required as part of an orthodontic treatment program, required for correction of an occlusal defect, encompassing orthognathic or prognathic surgical procedures, or removal of symptomatic bony impacted teeth;

Orthodontia and related services;

Orthotic Appliances, Repairs or Replacement - The replacement costs for changes due to obesity; routine maintenance due to normal wear and tear or negligence of items owned by the Insured; foot or shoe inserts, arch supports, special orthopedic shoes, heel lifts, heel or sole wedges, heel pads, or insoles whether custom-made or prefabricated; also excluded are cranial (head) remodeling band for the treatment of postitional non-synostotic plagiocephaly; and other protective head gear;

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;

Personal comfort and convenience items or services such as television, telephone, barber or beauty service, guest service and similar incidental services and supplies;

Prescription Drugs and Medications - Prescription drugs and medications that require a prescription and are dispensed at a Pharmacy for outpatient treatment, except as specifically Covered in the Covered Services Section of this Policy or as specifically provided in an optional pharmacy Rider.

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

Prosthetic Devices Repairs or Replacement - The replacement costs for any otherwise Covered device, including replacement for changes due to obesity; routine maintenance due to normal wear and tear or negligence of items owned by the Insured;

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

Reduction or Augmentation Mammoplasty - Reduction or augmentation mammoplasty is excluded unless associated with breast reconstruction surgery following a Medically Necessary mastectomy resulting from cancer;

Reversal of Sterilization Services - Those services and associated expenses related to reversal of voluntary sterilization;
Sex Transformation Services - 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;

Sexual Dysfunction - Any device, implant or self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence and anorgasmy;

Sleep Studies – Sleep studies provided within the home;

Smoking Cessation - Those services and supplies for smoking cessation programs and treatment of nicotine addiction;

Speech therapy or voice training when prescribed for stuttering or hoarseness;

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 including braces and orthotics;
Surrogate motherhood services and supplies, including, but not limited to, all services and supplies relating to the conception and pregnancy of the Insured acting as a surrogate mother;

Transplant Organ Removal - Those services and associated expenses for removal of an organ for the purposes of transplantation from a donor who is not Covered under the Policy unless the recipient is the 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 the Insured is donating organ or tissue to a person not Covered under the Policy;

Transplant Services and associated expenses involving temporary or permanent mechanical or animal organs;

Travel Expenses - Travel or transportation expenses, even though prescribed by a Provider, except as specified in the Covered Services Section;

Treatment for disorders relating to delays in learning, motor skills and communication, including any therapy for developmental delay;

Vision Aids, Associated Services - Those services and associated expenses for orthoptics or vision training, field charting, eye exercises, radial keratotomy, LASIK and other refractive eye surgery, low vision aids and services or other refractive surgery;

Vocational therapy;

Health services resulting from war or an act of war when the Insured is outside of the continental United States; and

Work hardening programs.

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