SECTION 6: EXCLUSIONS AND LIMITATIONS

6.1 The Group Contract does not cover the following items:

Any service or supply that is not Authorized in accordance with Our utilization management policies and procedures for the diagnosis or treatment of illness, injury or restoration of physiological or psychological functions or that is not received in accordance with the terms and conditions of the Group Contract;

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;

Any charges in excess of Eligible Charges;

Any charges in excess of a Benefit Maximum, Annual Maximum, Maximum Lifetime Benefit, or any other maximum or limit set forth in the Schedule of Payments or Certificate of Insurance;

Procedures and treatments that We determine, in Our sole and absolute discretion to be Experimental or Investigational;

Reconstruction or delayed procedures except as specified in the Schedule of Covered Services and in the case of traumatic injury when a significant anatomical or functional improvement can be anticipated;

Any services to the extent that payment for such services is, by law, covered by any governmental agency as a primary plan;

Care rendered to You by a relative or someone who ordinarily resides in Your household;

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

Illegal occupation. Services and or supplies rendered as a result of injuries sustained during the commission of or attempt to commit a felony or engagement in an illegal occupation; and

Court-ordered services or services that are a condition of probation or parole.

6.2 Specific services that are not Covered include but are not limited to (this is not an exhaustive list):

1. Services, supplies, equipment, facilities and related charges that are not expressly listed in Section 5, Covered Services, or excluded or limited under this Section 6 or Section 5.3.8, unless Covered under a rider or amendment to this Certificate of Insurance;
2. Acupuncture;
3. Allergy antigen and serum except for the treatment of systemic anaphalaxis;
4. Ambulance service except as outlined in the Schedule of Covered Services;
5. Autopsy;
6. Biofeedback except as Prior Authorized;
7. Blood, blood components, and blood products, including coagulation factors, whether derived from blood, artificially produced, or genetically engineered, except as specifically listed in the Schedule of Covered Services;
8. Blood clotting factors for chronic prophylactic or maintenance therapy;
9. Charges associated with transportation of blood, blood components, or blood products;
10. Charges for blood donors and blood donation except as specified in the Schedule of Covered Services;
11. Braces and supports needed for athletic participation or employment;
12. Hearing aids, including but not limited to cochlear implants, examinations to determine the need for hearing aids or in conjunction with the purchase of hearing aids, and hearing aid dispensing fees;
13. Clothing or shoes of any type, including but not limited to orthopedic shoes, children's corrective shoes, shoes used in conjunction with leg braces, and shoe inserts except for inserts and shoes for Members with diabetes or peripheral vascular disease;
14. Foot care, except for foot care required to treat manifestations of systemic disease causing circulatory problems,

such as diabetes or peripheral vascular disease. Foot care that is excluded from Coverage under this Group Contract includes, but is not limited to:

- Services for weak, strained, flat, unstable, or unbalanced foot or for a metatarsalgia or bunion. This does not apply to an open cutting operation.
- Treatment of hyperkeratotic lesions, corns, calluses, and nails;
- Removal or reduction of warts; and
- Removal of toenails (except Medically Necessary surgery for ingrown toenails).

15. Corrective Appliances that do not require prescription specifications and/or are used primarily for recreational sports;
16. Corrective Appliances used primarily for cosmetic purposes, including but not limited to cranial prostheses and molding helmets;
17. Repair and maintenance of Durable Medical Equipment and Corrective Appliances:
    (i) Repair and maintenance for routine servicing such as testing, cleaning, regulating and checking of equipment is not Covered except as specified in the Schedule of Covered Services.
    (ii) Except as specified in the Schedule of Covered Services, repair Coverage is limited to:
        (a) adjustment required by wear or by condition change when prescribed by a Provider; and
        (b) repairs necessary to make the equipment/appliance serviceable unless the repair costs exceed the cost of the equipment/appliance.
18. Except as specified in the Schedule of Covered Services, replacement Coverage for Durable Medical Equipment or Corrective Appliances is limited to once every two (2) years for irreparable damage and/or normal wear, or a significant change in medical condition. Replacement resulting from malicious damage, culpable neglect, or wrongful disposition of the equipment or device on the part of the Member are NOT Covered.
19. Cosmetic Services and Surgery and the complications incurred as a result of those services and surgeries;
20. Custodial Care and domiciliary care, residential care, protective and supportive care including, but not limited to, educational services, rest cures, and convalescent care;
21. Disposable medical supplies, dressings and splints unless used for treatment of fracture reductions or dislocations; medical equipment of an expendable nature including but not limited to incontinence pads, catheters, irrigation kits, anti-embolic stockings with a pressure gradient of less than 20 MM HG, and ace bandages;
22. Equipment or services primarily used for use in altering air quality or temperature;
23. Equipment primarily used for non-medical purposes;
24. Educational testing or psychological testing, unless part of a treatment program for Covered Services;
25. Exams for employment, school, camp, sports, licensing, insurance, adoption, marriage, driver's license, foreign travel, passports, or those ordered by a third party;
26. Exercise equipment;
27. Eye exercises and therapy;
28. Except as specified in the Schedule of Covered Services, family planning services, including but not limited to devices, pregnancy reduction procedures, and abortion services;
29. Food or food supplements, vitamins or other nutritional and over-the-counter electrolyte supplements except as specified in the Schedule of Covered Services or a Rider;
30. Genetic counseling and genetic studies that are not required for diagnosis or treatment of genetic abnormalities according to Our guideline;
31. Guest meals and accommodations;
32. Hair analysis, wigs and hair transplants;
33. Home services to help meet personal/family/domestic needs;

34. Hypnotherapy;
35. Immunizations for travel or employment;
36. Family planning and Infertility treatments, services supplies and devices, fetal reduction surgery, termination of pregnancy, and artificial reproductive technology including but not limited to: egg harvest, sperm donation, donor sperm or donor eggs, in vitro and in vivo fertilization (IVF), artificial insemination, gamete intrafallopian transfer (GIFT), and zygote intrafallopian transfer (ZIFT), embryo transplants and similar procedures, cryopreservation and storage of sperm, eggs and embryos, supplies, drug therapies and drugs;
37. Except as specified in the Section 5, Covered Services, Prescription Drugs and over-the-counter drugs or over-the-counter devices;
38. Injectable drugs available in an oral form that are being administered as an injection to provide benefits which would not otherwise be Covered under the Group Contract;
39. Vocational or employment counseling, and sex therapy;
40. Over-the-counter supplies such as ACE wraps/elastic supports/finger splints, orthotics (except for treatment of diabetes or peripheral vascular disease); take-home supplies;
41. Except as specified in the Schedule of Covered Services, oral and dental surgery and related services and supplies including:
    i. Services and supplies related to dental care, dental appliances, dental prostheses, dental implants, or dental X-rays;
    ii. Orthodontics, periodontics, endodontics, prosthodontics, preventive, cosmetic or restorative dentistry, even when associated with congenital anomalies;
    iii. Oral surgery that is required as part of an orthodontic treatment program;
    iv. Oral surgery that is required for the correction of an occlusal defect;
    v. Oral surgery that encompasses orthognathic, prosthodontics or prognathic surgical procedures;
    vi. Treatment of Temporomandibular Joint Disorders (TMJ);
    vii. Charges for Physicians' services or X-ray examinations involving one or more teeth, the tissue or structure around them, the alveolar process or the gums. This applies even if a condition requiring any of these services involves a part of the body other than the mouth, such as the treatment of Temporomandibular Joint Disorder or malocclusion involving joints or muscles by methods including, but not limited to crowning, wiring, or repositioning of teeth.
42. Outpatient oxygen and its administration unless specifically Prior Authorized;
43. Psychiatric evaluation or therapy and/or chemical dependency treatment when related to judicial or administrative proceedings or orders; when related to mental retardation, pervasive developmental disorder or autism; when required for school; for learning disabilities; when the Member is eligible for Social Security disability benefits for a mental or emotional disability; or for the purpose of submitting a disability application for a mental or emotional condition.
44. Psychological testing for learning disabilities, school-related issues, or for the purpose of obtaining or maintaining employment;
45. Inpatient treatment of “General Mental Illness” as defined in Section 14, Definitions;
46. Treatment of alcoholism provided by halfway houses, boot camps and wilderness programs and all treatments for chemical dependency and drug abuse;
47. Private duty nursing;
48. Private inpatient room, unless Medically Necessary or if a semi-private room is unavailable;
49. Personal comfort and convenience items including, but not limited to television and telephone, elevators, hoyer lifts (except as Prior Authorized by the Medical Director), shower/bath benches;
50. Rehabilitation services, including but not limited to cognitive therapy, physical therapy, occupational therapy, and speech therapy for developmental delay, school-related problems, apraxic disorders (unless caused by accident or

episodic illness), stuttering, autism, speech delay, articulation disorder, functional dysphonia, or speech problems resulting from psychoneurotic or personality disorders;

51. Sex transformation procedures, treatments, or studies;
52. Spinal manipulation, unless Covered by a rider or amendment;
53. Sports medicine treatment plans, surgery, Corrective Appliances, or artificial aids primarily intended to enhance athletic functions;
54. Voluntary sterilization and reversal of voluntary sterilization;
55. Surgery performed solely to address psychological or emotional factors;
56. [Maternity services and supplies and newborn nursery care, except as provided in the Schedule of Covered Services; surrogate motherhood services and supplies, including, but not limited to, all services and supplies relating to the conception and pregnancy] [Newborn nursery care, except as provided in the Schedule of Covered Services; maternity services that exceed the limits specified in the Schedule of Payments; and surrogate motherhood services and supplies, including, but not limited to, all services and supplies relating to the conception and pregnancy];
57. 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;
58. Travel, other than Emergency Service transportation by ambulance or Medically Necessary transportation Prior Authorized by Us;
59. Vision care and optometric services except as specified in the Schedule of Covered Services;
60. Services or supplies in connection with:
    i. examinations to determine the need for or change in prescription or other examination related to wearing eyeglasses or lenses of any type;
    ii. eyeglasses or lenses of any type, except as specified in the Schedule of Covered Services;
    iii. eye surgery, such as radial keratotomy, laser corneal resurfacing, or other surgery, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring); or
    iv. vision training or orthoptics;
61. Vocational therapy;
62. War-related sickness, 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;
63. Services resulting from war or acts of war;
64. Work hardening programs;
65. Work related injuries or illnesses when covered by workers compensation;
66. Weight reduction therapy, supplies and services, including but not limited to diet programs, tests, examinations or services and medical or surgical treatments such as intestinal bypass surgery, stomach stapling, balloon dilation, wiring of the jaw and other procedures of a similar nature, except where We determine them to be Medically Necessary.

6.3 Exclusion of Coverage for Pre-Existing Medical Conditions

Pre-existing Medical Conditions are those 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 six (6) month period prior to Your application for Coverage. Pre-existing Medical 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 Member Effective Date. If You are accepted for Coverage, Your premium rate will be calculated to include any Pre-existing Medical Condition that You disclosed on Your Enrollment Form, and such conditions will be Covered under the terms of Your Group Contract beginning on Your Effective Date. Any Pre-existing Medical 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.

6.4 Right to Authorize Payment

Anything in the Group Contract to the contrary notwithstanding, We reserve the right to Authorize payment for a service, supply, equipment or benefit which is otherwise not Covered or is limited or excluded. Coverage of a service, supply, equipment, or benefit not otherwise Authorized for payment under the Group Contract does not waive Our right to deny Coverage for the same in the future or obligate Us to cover the same for the same Member in the future or for any other Member at any time.