

**What is a benefit summary?**

This is a summary of what the plan does and does not cover. This summary can also help you understand your share of the costs. It's always best to review your Certificate of Coverage (COC) and check your coverage before getting any health services, when possible.

**What are the benefits of the Core Plan?****Find network care nearby.**

A network is a group of health care providers and facilities that have a contract with UnitedHealthcare. You have quality network care nearby. If you travel, you'll get access to a national network to help lower your costs.

- > **There's coverage if you need to go out of the network.** Out-of-network means that a provider does not have a contract with us. Choose what's best for you. Just remember out-of-network providers will likely charge you more.
- > **There's no need to choose a primary care provider (PCP) or get referrals to see a specialist.** Consider a PCP; they can be helpful in managing your care.
- > **Preventive care is covered 100% in our network.**

**Are you a member?**

Easily manage your benefits online at [myuhc.com](http://myuhc.com)® and on the go with the **UnitedHealthcare Health4Me™** mobile app.

For questions, call the member phone number on your health plan ID card.

**Not enrolled yet?** Learn more about this plan and search for network doctors or hospitals at [welcometouhc.com/core](http://welcometouhc.com/core) or call **1-866-873-3903**, TTY **711**, 8 a.m. to 8 p.m. local time, Monday through Friday.

**Benefits At-A-Glance****What you may pay for network care**

This chart is a simple summary of the costs you may have to pay when you receive care in the network. It doesn't include all of the deductibles and co-payments you may have to pay. You can find more benefit details beginning on page 2.

| <b>Co-payment</b><br>(Your cost for an office visit) | <b>Individual Deductible</b><br>(Your cost before the plan starts to pay) | <b>Co-insurance</b><br>(Your cost share after the deductible) |
|--|---|---|
| \$30   | \$1,500   | 20%   |

This Benefit Summary is to highlight your Benefits. Don't use this document to understand your exact coverage for certain conditions. If this Benefit Summary conflicts with the Certificate of Coverage (COC), Riders, and/or Amendments, those documents are correct. Review your COC for an exact description of the services and supplies that are and are not covered, those which are excluded or limited, and other terms and conditions of coverage.

## Your Costs

In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

### Your cost if you use Network Benefits

### Your cost if you use Out-of-Network Benefits

#### Deductible - Combined Network and Out-of-Network Benefits

##### What is a deductible?

The deductible is the amount you have to pay for covered health care services (common medical event) before your health plan begins to pay. The deductible may not apply to all services. You may have more than one type of deductible.

- > Your co-pays don't count towards meeting the deductible unless otherwise described within the specific common medical event.
- > All individual deductible amounts will count towards meeting the family deductible, but an individual will not have to pay more than the individual deductible amount.
- > This benefit plan includes a per occurrence deductible that applies to certain common medical events. This per occurrence deductible must be met prior to and in addition to the medical deductible.

|                                 |                  |                  |
|---------------------------------|------------------|------------------|
| Medical Deductible - Individual | \$1,500 per year | \$1,500 per year |
| Medical Deductible - Family     | \$3,000 per year | \$3,000 per year |

#### Out-of-Pocket Limit - Combined Network and Out-of-Network Benefits

##### What is an out-of-pocket limit?

The most you pay during a policy year before your health plan begins to pay 100%. Once you reach the out-of-pocket limit, your health plan will pay for all covered services. This will not include any amounts over the amount we allow when you see an out-of-network provider.

- > All individual out-of-pocket limit amounts will count towards meeting the family out-of-pocket limit, but an individual will not have to pay more than the individual out-of-pocket limit amount.
- > Your co-pays, co-insurance, deductibles and per occurrence deductibles (including pharmacy) count towards meeting the out-of-pocket limit.

|                                  |                   |  |
|----------------------------------|-------------------|--|
| Out-of-Pocket Limit - Individual | \$5,750 per year  | You do not have an out-of-pocket limit |
| Out-of-Pocket Limit - Family     | \$11,500 per year | You do not have an out-of-pocket limit |

## Your Costs

---

### **What is co-insurance?**

Co-insurance is your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe. Co-insurance is not the same as a co-payment (or co-pay).

### **What is a co-payment?**

A co-payment (co-pay) is a fixed amount (for example, \$15) you pay for a covered health care service, usually when you receive the service. You will pay a co-pay or the allowed amount, whichever is less. The amount can vary by the type of covered health care service. Please see the specific common medical event to see if a co-pay applies and how much you have to pay.

### **What is Prior Authorization?**

Prior Authorization is getting approval before you can get access to medicine or services. Services that require prior authorization are noted in the list of Common Medical Events. To get approval, call the member phone number on your health plan ID card.

### **Want more information?**

Find additional definitions in the glossary at [justplainclear.com](http://justplainclear.com).

## Your Costs

Following is a list of services that your plan covers in alphabetical order. In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

| <b>Common Medical Event</b>  | <b>Your cost if you use Network Benefits</b>                                 | <b>Your cost if you use Out-of-Network Benefits</b>          |
|--|--|--|
| <b>Acupuncture Services</b>  |  |  |
| Limited to 12 treatments per year.   | \$30 co-pay per visit. A deductible does not apply.                          | \$30 co-pay per visit. A deductible does not apply.          |
| <b>Ambulance Services - Emergency and Non-Emergency</b>  |  |  |
|  | 20% co-insurance, after the medical deductible has been met.                 | 20% co-insurance, after the medical deductible has been met. |
|  | Prior Authorization is required for Non-Emergency Ambulance.                 | Prior Authorization is required for Non-Emergency Ambulance. |
| <b>Autism Spectrum Disorders</b>   |  |  |
| No visit limits are applicable to an autism service provider for the treatment of Autism Spectrum Disorders. Any applicable limits for speech therapy, occupational therapy and physical therapy provided by or supervised by an autism service provider stated under Rehabilitative Services - Outpatient Therapy do not apply to treatment of Autism Spectrum Disorders for Covered Persons under 21 years of age. | The amount you pay is based on where the covered health service is provided. |  |
|  | Prior Authorization is required for certain services.                        | Prior Authorization is required for certain services.        |
| <b>Clinical Trials</b>   |  |  |
|  | The amount you pay is based on where the covered health service is provided. |  |
|  | Prior Authorization is required.   | Prior Authorization is required.                             |
| <b>Congenital Heart Disease (CHD) Surgeries</b>  |  |  |
|  | 20% co-insurance, after the medical deductible has been met.                 | 50% co-insurance, after the medical deductible has been met. |
|  |  | Prior Authorization is required.                             |
| <b>Dental Services - Accident Only</b>   |  |  |
|  | 20% co-insurance, after the medical deductible has been met.                 | 20% co-insurance, after the medical deductible has been met. |
|  | Prior Authorization is required.   | Prior Authorization is required.                             |

## Your Costs

| Common Medical Event  | Your cost if you use Network Benefits  | Your cost if you use Out-of-Network Benefits   |
|---|--|--|
| <b>Diabetes Services</b>  |  |  |
| Diabetes Self Management and Training/Diabetic Eye Examinations/ Foot Care:   | The amount you pay is based on where the covered health service is provided.   |  |
| Diabetes Self Management Items:   | The amount you pay is based on where the covered health service is provided under Durable Medical Equipment or in the Prescription Drug Rider. | Prior Authorization is required for Durable Medical Equipment that costs more than \$1,000.  |
| <b>Durable Medical Equipment</b>  |  |  |
| Limited to a single purchase of a type of Durable Medical Equipment (including repair and replacement) every 3 years. This limit does not apply to wound vacuums. | 20% co-insurance, after the medical deductible has been met.   | 20% co-insurance, after the medical deductible has been met.<br><br>Prior Authorization is required for Durable Medical Equipment that costs more than \$1,000.                                  |
| <b>Electronic Visits</b>  |  |  |
|   | The amount you pay is based on where the covered health service is provided.   |  |
| <b>Emergency Health Services - Outpatient</b>   |  |  |
|   | 20% co-insurance after you pay the \$150 per occurrence deductible per visit and the medical deductible has been met.                          | 20% co-insurance after you pay the \$150 per occurrence deductible per visit and the medical deductible has been met.<br><br>Notification is required if confined in an Out-of-Network Hospital. |
| <b>Hearing Aids</b>   |  |  |
| Limited to a single purchase (including repair and replacement) per hearing impaired ear every 3 years.   | 20% co-insurance, after the medical deductible has been met.   | 20% co-insurance, after the medical deductible has been met.   |
| <b>Home Health Care</b>   |  |  |
| Limited to 60 visits per year.  | 20% co-insurance, after the medical deductible has been met.   | 20% co-insurance, after the medical deductible has been met.<br><br>Prior Authorization is required.   |
| <b>Hospice Care</b>   |  |  |
|   | 20% co-insurance, after the medical deductible has been met.   | 20% co-insurance, after the medical deductible has been met.<br><br>Prior Authorization is required for Inpatient Stay.  |

## Your Costs

| Common Medical Event  | Your cost if you use Network Benefits  | Your cost if you use Out-of-Network Benefits  |
|---|--|---|
| <b>Hospital - Inpatient Stay</b>  |  |   |
|   | 20% co-insurance, after the medical deductible has been met.                 | 50% co-insurance, after the medical deductible has been met.<br><br>Prior Authorization is required.                      |
| <b>Lab, X-Ray and Diagnostics - Outpatient</b>  |  |   |
|   | 20% co-insurance, after the medical deductible has been met.                 | 20% co-insurance, after the medical deductible has been met.<br><br>Prior Authorization is required for sleep studies.    |
| <b>Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient</b> |  |   |
|   | \$150 co-pay per service, after the medical deductible has been met.         | \$150 co-pay per service, after the medical deductible has been met.<br><br>Prior Authorization is required.              |
| <b>Mental Health Services</b>   |  |   |
| Inpatient:  | 20% co-insurance, after the medical deductible has been met.                 | 50% co-insurance, after the medical deductible has been met.  |
| Outpatient:   | \$30 co-pay per visit. A deductible does not apply.                          | \$30 co-pay per visit. A deductible does not apply.   |
| Partial Hospitalization/Intensive Outpatient Treatment:                                       | 20% co-insurance, after the medical deductible has been met.                 | 20% co-insurance, after the medical deductible has been met.<br><br>Prior Authorization is required for certain services. |
| <b>Neurobiological Disorders – Autism Spectrum Disorder Services</b>                          |  |   |
| Inpatient:  | 20% co-insurance, after the medical deductible has been met.                 | 50% co-insurance, after the medical deductible has been met.  |
| Outpatient:   | \$30 co-pay per visit. A deductible does not apply.                          | \$30 co-pay per visit. A deductible does not apply.   |
| Partial Hospitalization/Intensive Outpatient Treatment:                                       | 20% co-insurance, after the medical deductible has been met.                 | 20% co-insurance, after the medical deductible has been met.<br><br>Prior Authorization is required for certain services. |
| <b>Neurodevelopmental Therapy</b>   |  |   |
|   | The amount you pay is based on where the covered health service is provided. |   |
| <b>Ostomy Supplies</b>  |  |   |
|   | 20% co-insurance, after the medical deductible has been met.                 | 20% co-insurance, after the medical deductible has been met.  |

## Your Costs

| Common Medical Event   | Your cost if you use Network Benefits  | Your cost if you use Out-of-Network Benefits   |
|--|--|--|
| <b>Pharmaceutical Products - Outpatient</b>  |  |  |
| This includes medications given at a doctor's office, or in a Covered Person's home.   | 20% co-insurance, after the medical deductible has been met.   | 20% co-insurance, after the medical deductible has been met.   |
| <b>Phenylketonuria Treatment</b>   |  |  |
| Professional medical services provided under the supervision of a Physician.   | The amount you pay is based on where the covered health service is provided.   |  |
| Dietary formula products to achieve and maintain normalized blood levels of phenylalanine and adequate nutritional status.                               | 20% co-insurance, after the medical deductible has been met or as stated under the Outpatient Prescription Drug Rider. | 50% co-insurance, after the medical deductible has been met or as stated under the Outpatient Prescription Drug Rider.   |
| <b>Physician Fees for Surgical and Medical Services</b>  |  |  |
|  | 20% co-insurance, after the medical deductible has been met.   | 20% co-insurance, after the medical deductible has been met.   |
| <b>Physician's Office Services - Sickness and Injury</b>   |  |  |
| Primary Physician Office Visit   | \$30 co-pay per visit. A deductible does not apply.  | \$30 co-pay per visit. A deductible does not apply.  |
| Benefits under this category include services performed by a Naturopathic Physician.   |  |  |
| Specialist Physician Office Visit  | \$30 co-pay per visit. A deductible does not apply.  | \$30 co-pay per visit. A deductible does not apply.  |
|  |  | Prior Authorization is required for Breast Cancer Genetic Test Counseling (BRCA) for women at higher risk for breast cancer.   |
| Additional co-pays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work. |  |  |
| <b>Pregnancy - Maternity Services</b>  |  |  |
|  | The amount you pay is based on where the covered health service is provided.   |  |
|  |  | Prior Authorization is required if the stay in the hospital is longer than 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery. |
| <b>Prescription Drug Benefits</b>  |  |  |
| Prescription drug benefits are shown in the Prescription Drug benefit summary.   |  |  |

## Your Costs

| Common Medical Event  | Your cost if you use Network Benefits   | Your cost if you use Out-of-Network Benefits  |
|---|---|---|
| <b>Preventive Care Services</b>   |   |   |
| Physician Office Services, Scopic Procedures, Lab, X-Ray or other preventive tests.   | You pay nothing. A deductible does not apply.                                       | You pay nothing. A deductible does not apply.   |
| <p>Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a co-pay, co-insurance or deductible.</p>   |   |   |
| <b>Prosthetic Devices</b>   |   |   |
| Limited to a single purchase of each type of prosthetic device every 3 years.   | 20% co-insurance, after the medical deductible has been met.                        | 20% co-insurance, after the medical deductible has been met.                                |
|   |   | <p>Prior Authorization is required for Prosthetic Devices that costs more than \$1,000.</p> |
| <b>Reconstructive Procedures</b>  |   |   |
|   | <p>The amount you pay is based on where the covered health service is provided.</p> |   |
|   |   | <p>Prior Authorization is required.</p>   |
| <b>Rehabilitation and Habilitative Services - Outpatient Therapy and Manipulative Treatment</b>   |   |   |
| <p>Limited to:</p> <ul style="list-style-type: none"> <li>30 visits of physical therapy.</li> <li>30 visits of occupational therapy.</li> <li>30 visits of speech therapy.</li> <li>20 visits of pulmonary rehabilitation.</li> <li>36 visits of cardiac rehabilitation.</li> <li>30 visits of post-cochlear implant aural therapy.</li> <li>20 visits of cognitive rehabilitation therapy.</li> <li>20 visits of manipulative treatments.</li> </ul> | <p>\$30 co-pay per visit. A deductible does not apply.</p>                          | <p>\$30 co-pay per visit. A deductible does not apply.</p>                                  |
| <b>Scopic Procedures - Outpatient Diagnostic and Therapeutic</b>  |   |   |
| <p>Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.</p>   | <p>20% co-insurance, after the medical deductible has been met.</p>                 | <p>20% co-insurance, after the medical deductible has been met.</p>                         |
| <b>Skilled Nursing Facility / Inpatient Rehabilitation Facility Services</b>  |   |   |
| <p>Limited to 60 days per year.</p>   | <p>20% co-insurance, after the medical deductible has been met.</p>                 | <p>50% co-insurance, after the medical deductible has been met.</p>                         |
|   |   | <p>Prior Authorization is required.</p>   |



## Your Costs

| Common Medical Event  | Your cost if you use Network Benefits  | Your cost if you use Out-of-Network Benefits  |
|---|--|---|
| <b>Substance Use Disorder Services</b>  |  |   |
| Inpatient:  | 20% co-insurance, after the medical deductible has been met.   | 50% co-insurance, after the medical deductible has been met.  |
| Outpatient:   | \$30 co-pay per visit. A deductible does not apply.  | \$30 co-pay per visit. A deductible does not apply.   |
| Partial Hospitalization/Intensive Outpatient Treatment:   | 20% co-insurance, after the medical deductible has been met.   | 20% co-insurance, after the medical deductible has been met.<br><br>Prior Authorization is required for certain services. |
| <b>Surgery - Outpatient</b>   |  |   |
|   | 20% co-insurance, after the medical deductible has been met.   | 20% co-insurance, after the medical deductible has been met.  |
| <b>Therapeutic Treatments - Outpatient</b>  |  |   |
| Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology. | \$100 co-pay per visit, after the medical deductible has been met.   | \$100 co-pay per visit, after the medical deductible has been met.  |
| <b>Transplantation Services</b>   |  |   |
| Network Benefits must be received at a designated facility.   | The amount you pay is based on where the covered health service is provided.<br><br>Prior Authorization is required. | Prior Authorization is required.  |
| <b>Urgent Care Center Services</b>  |  |   |
|   | \$50 co-pay per visit. A deductible does not apply.  | \$50 co-pay per visit. A deductible does not apply.   |
| Additional co-pays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example, surgery and lab work.           |  |   |
| <b>Virtual Visits</b>   |  |   |
| Access to Virtual Visits and prescription services may not be available in all states or for all groups.  | \$10 co-pay per visit. A deductible does not apply.  | \$10 co-pay per visit. A deductible does not apply.   |

## Services your plan does not cover (Exclusions)

---

It is recommended that you review your COC, Amendments and Riders for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

### Alternative Treatments

Acupressure; aromatherapy; hypnotism; massage therapy; rolfing; art therapy, music therapy, dance therapy, horseback therapy; and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in Section 1 of the COC.

### Dental

Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia). This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services – Accident Only in Section 1 of the COC. This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Policy, limited to: Transplant preparation; prior to initiation of immunosuppressive drugs; the direct treatment of acute traumatic Injury, cancer or cleft palate. Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication. Endodontics, periodontal surgery and restorative treatment are excluded. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include: extraction, restoration and replacement of teeth; medical or surgical treatments of dental conditions; and services to improve dental clinical outcomes. This exclusion does not apply to accidental-related dental services for which Benefits are provided as described under Dental Services – Accidental Only in Section 1 of the COC. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services – Accident Only in Section 1 of the COC. Dental braces (orthodontics). Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly.

### Devices, Appliances and Prosthetics

Devices used specifically as safety items or to affect performance in sports-related activities. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. Cranial banding. The following items are excluded, even if prescribed by a Physician: blood pressure cuff/monitor; enuresis alarm; non-wearable external defibrillator; trusses and ultrasonic nebulizers. Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under Durable Medical Equipment in Section 1 of the COC. Oral appliances for snoring. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

### Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill. Self-injectable medications except as described in the Outpatient Prescription Drug Rider. This exclusion does not apply to medications which, due to their characteristics, must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office. Over-the-counter drugs and treatments. This exclusion does not apply to prescribed over-the-counter FDA-approved contraceptives or over-the-counter medications that have an A or B recommendation from the U.S. Preventive Services Task Force (USPSTF) when prescribed by a Network provider for which Benefits are available, without cost sharing, as described under Preventive Care Services in Section 1 of the COC. Growth hormone therapy. New Pharmaceutical Products and/or new dosage forms until the date they are reviewed. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.

## Services your plan does not cover (Exclusions)

---

### Experimental, Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in Section 1 of the COC.

### Foot Care

Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under Diabetes Services in Section 1 of the COC. Nail trimming, cutting, or debriding. Hygienic and preventive maintenance foot care. Examples include: cleaning and soaking the feet; applying skin creams in order to maintain skin tone. This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes. Treatment of flat feet. Treatment of subluxation of the foot. Shoes; shoe orthotics; shoe inserts and arch supports.

### Medical Supplies

Prescribed or non-prescribed medical supplies and disposable supplies. Examples include: compression stockings, ace bandages, gauze and dressings, urinary catheters. This exclusion does not apply to:

- Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under Durable Medical Equipment in Section 1 of the COC.
- Diabetic supplies for which Benefits are provided as described under Diabetes Services in Section 1 of the COC.
- Ostomy supplies for which Benefits are provided as described under Ostomy Supplies in Section 1 of the COC.

Tubing and masks, except when used with Durable Medical Equipment as described under Durable Medical Equipment in Section 1 of the COC. Supplies not primarily intended for medical use.

### Mental Health

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Mental Health Services as treatments for R & T code conditions as listed within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep-wake disorders, feeding disorders, binge eating disorders, sexual dysfunction, communication disorders, motor disorders, neurological disorders and other disorders with a known physical basis. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilic disorder. Educational services that are focused on primarily building skills and capabilities in communication, social interaction and learning. Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act. Motor disorders and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Intellectual disabilities as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Autism spectrum disorder as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Mental Health Services as a treatment for other conditions that may be a focus of clinical attention as listed in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. All unspecified disorders in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 9 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which may be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in Section 1 of the COC and in the Schedule of Benefits.
- Not otherwise excluded in Section 2 of the COC.

## Services your plan does not cover (Exclusions)

---

### Neurobiological Disorders – Autism Spectrum Disorder

Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services. Intellectual disability as the primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act. Learning, motor disorders and communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association and which are not a part of Autism Spectrum Disorder. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilic disorder. All unspecified disorders in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Health services and supplies that do not meet the definition of a Covered Health Service – see the definition in Section 9 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which may be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in Section 1 of the COC and in the Schedule of Benefits.
- Not otherwise excluded in Section 2 of the COC.

### Nutrition

Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:

- Nutritional education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Enteral feedings, even if the sole source of nutrition. Infant formula and donor breast milk. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods). This exclusion does not apply to the following: dietary formula products for which Benefits are provided as described under Phenylketonuria (PKU) Treatment Services in Section 1 of the COC; items listed above that are prescribed by a licensed provider for the treatment of diabetes.

### Personal Care, Comfort or Convenience

Television; telephone; beauty/barber service; guest service. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include: air conditioners, air purifiers and filters, dehumidifiers; batteries and battery chargers; breast pumps (This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement); car seats; chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners; exercise equipment; home modifications such as elevators, handrails and ramps; hot tubs; humidifiers; Jacuzzis; mattresses; medical alert systems; motorized beds; music devices; personal computers, pillows; power-operated vehicles; radios; saunas; stair lifts and stair glides; strollers; safety equipment; treadmills; vehicle modifications such as van lifts; video players, whirlpools.

## Services your plan does not cover (Exclusions)

---

### Physical Appearance

Cosmetic Procedures. See the definition in Section 9 of the COC. Examples include: pharmacological regimens, nutritional procedures or treatments. Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). Skin abrasion procedures performed as a treatment for acne. Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. Treatment for skin wrinkles or any treatment to improve the appearance of the skin. Treatment for spider veins. Hair removal or replacement by any means. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See Reconstructive Procedures in Section 1 of the COC. Treatment of benign gynecomastia (abnormal breast enlargement in males). Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded. Wigs regardless of the reason for the hair loss.

### Procedures and Treatments

Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, and brachioplasty. Medical and surgical treatment of excessive sweating (hyperhidrosis). Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. Rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly or Autism Spectrum Disorder. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident. Psychosurgery. Sex transformation operations and related services. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter. Biofeedback services for psychiatric conditions other than generalized anxiety disorder. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea. Surgical and non-surgical treatment of obesity. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings. Breast reduction surgery except as coverage is required by the Women's Health and Cancer Rights Act of 1998 for which Benefits are described under Reconstructive Procedures in Section 1 of the COC. In vitro fertilization regardless of the reason for treatment.

### Providers

Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. Services performed by a provider with your same legal residence. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider has not been actively involved in your medical care prior to ordering the service, or is not actively involved in your medical care after the service is received. This exclusion does not apply to mammography.

### Reproduction

Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility. Surrogate parenting, donor eggs, donor sperm and host uterus. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue. The reversal of voluntary sterilization.

## Services your plan does not cover (Exclusions)

---

### Services Provided under Another Plan

Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes coverage required by workers' compensation, no-fault auto insurance, or similar legislation. This exclusion does not apply to Enrolling Groups that are not required by law to purchase or provide, through other arrangements, workers' compensation insurance for employees, owners and/or partners. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.

### Substance Use Disorders

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Educational services that are focused on primarily building skills and capabilities in communication, social interaction and learning. Substance-induced sexual dysfunction disorders and substance-induced sleep disorders. Gambling disorders. All unspecified disorders in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Health services and supplies that do not meet the definition of a Covered Health Service – see the definition in Section 9 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which may be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in Section 1 of the COC and in the Schedule of Benefits.
- Not otherwise excluded in Section 2 of the COC.

### Transplants

Health services for organ and tissue transplants, except those described under Transplantation Services in Section 1 of the COC. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.) Health services for transplants involving permanent mechanical or animal organs except as described under Transplantation Services in Section 1 of the COC.

### Travel

Health services provided in a foreign country, unless required as Emergency Health Services. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services may be reimbursed. This exclusion does not apply to the following: ambulance transportation for which Benefits are provided as described under Ambulance Services in Section 1 of the COC; travel expenses for clinical trials services for which Benefits are provided as described under Clinical Trials in Section 1 of the COC for the treatment of cancer that is primarily for and essential to the medical care of the Covered Person; travel expenses for transplantation services for which Benefits are provided as described under Transplantation Services in Section 1 of the COC; travel and lodging expenses are excluded if the Covered Person is a donor.

### Types of Care

Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain. Custodial care or maintenance care; domiciliary care. Private Duty Nursing. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under Hospice Care in Section 1 of the COC. Rest cures; services of personal care attendants. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

## Services your plan does not cover (Exclusions)

---

### Vision and Hearing

Purchase cost and fitting charge for eye glasses and contact lenses. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants). Eye exercise or vision therapy. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser, and other refractive eye surgery. Bone anchored hearing aids except when either of the following applies: For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid. For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. More than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled under the Policy. Repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage criteria, other than for malfunctions. Routine vision examinations, including refractive examinations to determine the need for vision correction.

### All Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 9 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which are all of the following: Medically Necessary; described as a Covered Health Service in Section 1 of the COC and Schedule of Benefits; and not otherwise excluded in Section 2 of the COC. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when: required solely for purposes of school, sports or camp, travel, career or employment, insurance, marriage or adoption; related to judicial or administrative proceedings or orders; conducted for purposes of medical research (This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in Section 1 of the COC); required to obtain or maintain a license of any type. 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. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war, or terrorism in non-war zones. Health services received after the date your coverage under the Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Policy ended. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy. In the event an Out-of-Network provider waives co-payments, co-insurance and/or any deductible for a particular health service, no Benefits are provided for the health service for which the co-payments, co-insurance and/or deductible are waived. Charges in excess of Eligible Expenses or in excess of any specified limitation. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products. Autopsy. Foreign language and sign language services. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service. For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

#### For Internal Use only:

AKM802ATLU17

Item#      Rev. Date

405-3123

0516

B14-014/Sep/Emb/24197/2011

**THIS PAGE INTENTIONALLY LEFT BLANK**

---

---