UnitedHealthcare®
A UnitedHealth Group Company

YOUR BENEFITS

Benefit Summary

California - Choice Plus
Balanced Value - 40/1000/70% Plan 5ES

We know that when people know more about their health and health care, they can make better informed health care decisions. We want to help you understand more about your health care and the resources that are available to you.

- **myuhc.com®** – Take advantage of easy, time-saving online tools. You can check your eligibility, benefits, claims, claim payments, search for a doctor and hospital and much, much more.
- **24-hour nurse support** – A nurse is a phone call away and you have other health resources available 24-hours a day, 7 days a week to provide you with information that can help you make informed decisions. Just call the number on the back of your ID card.
- **Customer Care telephone support** – Need more help? Call a customer care professional using the toll-free number on the back of your ID card. Get answers to your benefit questions or receive help looking for a doctor or hospital.

PLAN HIGHLIGHTS

Types of Coverage	Network Benefits	Non-Network Benefits
Annual Deductible		
Individual Deductible	$1,000 per year	$2,000 per year
Family Deductible	$3,000 per year	$6,000 per year

> Member Copayments do not accumulate towards the Deductible.

> No one in the family is eligible for benefits until the family coverage deductible is met.

> This benefit plan contains a Per Occurrence Deductible that applies to certain Covered Health Services. This Per Occurrence Deductible must be met prior to and in addition to the Annual Deductible.

Out-of-Pocket Maximum		
Individual Out-of-Pocket Maximum	$5,000 per year	$10,000 per year
Family Out-of-Pocket Maximum	$10,000 per year	$20,000 per year

> The Out-of-Pocket Maximum includes the Annual Deductible. The Out-of-Pocket Maximum does not include the Per Occurrence Deductible.

> If more than one person in a family is covered under the Policy, the individual Out-of-Pocket Maximum stated above does not apply.

> Member Copayments do not accumulate towards the Out-of-Pocket Maximum.

Benefit Plan Coinsurance - The Amount We Pay		
	70% after Deductible has been met.	50% after Deductible has been met.
Maximum Policy Benefit		
The maximum amount we will pay during the entire period of time you are enrolled under the Policy.	Combined Network and Non-Network Maximum of $5,000,000 per Covered Person.	

This Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary conflicts in any way with the Certificate of Coverage (COC), the COC shall prevail. It is recommended that you review your COC 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.

CAWGJ5ES07

Item#	Rev. Date	Benefit Accumulator	
400-3827	1109	Calendar Year	PVN/Sep/NonEmb/56269

UnitedHealthcare Insurance Company

Prescription Drug Benefits

Prescription drug benefits are shown under separate cover.

Information on Benefit Limits

> The Annual Deductible, Out-of-Pocket Maximum and Benefit limits are calculated on a calendar year basis.

> All Benefits are reimbursed based on Eligible Expenses. For a definition of Eligible Expenses, please refer to your Certificate of Coverage.

> When Benefit limits apply, the limit refers to any combination of Network and Non-Network Benefits unless specifically stated in the Benefit category.

MOST COMMONLY USED BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Physician's Office Services - Sickness and Injury		
Primary Physician Office Visit	100% after you pay a $40 Copayment per visit.	50% after Deductible has been met.
Specialist Physician Office Visit	100% after you pay a $60 Copayment per visit.	50% after Deductible has been met.

> In addition to the visit Copayment, the applicable Copayment or Deductible/Coinsurance applies when these services are done: CT, PET, MRI, Nuclear Medicine; Pharmaceutical Products; Scopic Procedures; Surgery; Therapeutic Treatments.

Preventive Care Services		
Covered Health Services include but are not limited to:		
Primary Physician Office Visit	100% after you pay a $40 Copayment per visit.	Non-Network Benefits are not available.
Specialist Physician Office Visit	100% after you pay a $60 Copayment per visit.	
Lab, X-Ray or other preventive tests	70% after Deductible has been met.	
We pay for Covered Health Services incurred if you participate in the Expanded Alpha Feto Protein (AFP) program, a statewide prenatal testing program administered by the State Department of Health Services.		
Urgent Care Center Services		
	100% after you pay a $125 Copayment per visit.	50% after Deductible has been met.

> In addition to the visit Copayment, the applicable Copayment or Deductible/Coinsurance applies when these services are done: CT, PET, MRI, Nuclear Medicine; Pharmaceutical Products; Scopic Procedures; Surgery; Therapeutic Treatments.

Emergency Health Services - Outpatient		
	100% after you pay a $250 Copayment per visit.	100% after you pay a $250 Copayment per visit. *Pre-service Notification is required if results in an Inpatient Stay.*
Hospital - Inpatient Stay		
	70% after: Per Occurrence Deductible of $500 and Annual Deductible have been met.	50% after: Per Occurrence Deductible of $500 and Annual Deductible have been met. *Pre-service Notification is required.*

Types of Coverage	Network Benefits	Non-Network Benefits
Ambulance Service - Emergency and Non-Emergency		
Ground Ambulance	70% after Deductible has been met.	70% after Network Deductible has been met.
Air Ambulance	70% after Deductible has been met. *Pre-service Notification is required for Non-Emergency Ambulance.*	70% after Network Deductible has been met. *Pre-service Notification is required for Non-Emergency Ambulance.*
Congenital Heart Disease (CHD) Surgeries		
	70% after: Per Occurrence Deductible of $500 and Annual Deductible have been met.	50% after: Per Occurrence Deductible of $500 and Annual Deductible have been met. Benefits are limited to $30,000 per surgery. *Pre-service Notification is required.*
Dental Services - Accident Only		
Benefits are limited as follows: $3,000 maximum per year $900 maximum per tooth	70% after Deductible has been met. *Pre-service Notification is required.*	70% after Network Deductible has been met. *Pre-service Notification is required.*
Diabetes Services		
Diabetes Self Management and Training Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this Benefit Summary.	*Pre-service Notification is required for Durable Medical Equipment and Diabetes Equipment in excess of $1,000.*
Durable Medical Equipment		
Benefits are limited as follows: $2,500 per year and are limited to a single purchase of a type of Durable Medical Equipment (including repair and replacement) every three years. This limit does not apply to braces that stabilize an injured body part and braces to treat curvature of the spine.	70% after Deductible has been met.	50% after Deductible has been met. *Pre-service Notification is required for Durable Medical Equipment in excess of $1,000.*
Hearing Aids		
Benefits are limited as follows: $2,500 per year and are limited to a single purchase (including repair/ replacement) every three years.	70% after Deductible has been met.	50% after Deductible has been met.
Home Health Care		
Benefits are limited as follows: 100 visits per year	70% after Deductible has been met.	50% after Deductible has been met. *Pre-service Notification is required.*
Hospice Care		
	70% after Deductible has been met.	50% after Deductible has been met. *Pre-service Notification is required for Inpatient stays.*

ADDITIONAL CORE BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Lab, X-Ray and Diagnostics - Outpatient		
For Preventive Lab, X-Ray and Diagnostics, refer to the Preventive Care Services category.	70% after Deductible has been met.	50% after Deductible has been met.
Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient		
	70% after Deductible has been met.	50% after Deductible has been met.
Ostomy Supplies		
	70% after Deductible has been met.	50% after Deductible has been met.
Pharmaceutical Products - Outpatient		
This includes medications administered in an outpatient setting, in the Physician's Office and by a Home Health Agency.	70% after Deductible has been met.	50% after Deductible has been met.
Physician Fees for Surgical and Medical Services		
	70% after Deductible has been met.	50% after Deductible has been met.
Pregnancy - Maternity Services		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
	For services provided in the Physician's Office, a Copayment will only apply to the initial office visit.	*Pre-service Notification is required if the Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.*
Prosthetic Devices		
	70% after Deductible has been met.	50% after Deductible has been met.
Reconstructive Procedures		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
		Pre-service Notification is required.
Rehabilitation Services - Outpatient Therapy and Chiropractic Treatment		
Benefits are limited as follows:	100% after you pay a $40 Copayment per visit.	50% after Deductible has been met.
24 visits of chiropractic treatment 20 visits of physical therapy 20 visits of occupational therapy 20 visits of speech therapy 20 visits of pulmonary rehabilitation 36 visits of cardiac rehabilitation 30 visits of post-cochlear implant aural therapy		*Pre-service Notification is required for certain services.*

Types of Coverage	Network Benefits	Non-Network Benefits
Scopic Procedures - Outpatient Diagnostic and Therapeutic		
Diagnostic scopic procedures include, but are not limited to: Colonoscopy Sigmoidoscopy Endoscopy For Preventive Scopic Procedures, refer to the Preventive Care Services category.	70% after Deductible has been met.	50% after Deductible has been met.
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services		
Benefits are limited as follows: 60 days per year	70% after Deductible has been met.	50% after Deductible has been met. *Pre-service Notification is required.*
Surgery - Outpatient		
	70% after: Per Occurrence Deductible of $250 and Annual Deductible have been met.	50% after: Per Occurrence Deductible of $250 and Annual Deductible have been met.
Therapeutic Treatments - Outpatient		
Therapeutic treatments include, but are not limited to: Dialysis Intravenous chemotherapy or other intravenous infusion therapy Radiation oncology	70% after Deductible has been met.	50% after Deductible has been met. *Pre-service Notification is required for certain services.*
Transplantation Services		
	70% after: Per Occurrence Deductible of $500 and Annual Deductible have been met. For Network Benefits, services must be received at a Designated Facility. *Pre-service Notification is required.*	50% after: Per Occurrence Deductible of $500 and Annual Deductible have been met. Benefits are limited to $30,000 per Transplant. *Pre-service Notification is required.*
Vision Examinations		
Benefits are limited as follows: 1 exam every 2 years	100% after you pay a $40 Copayment per visit.	Non-Network Benefits are not available.

STATE MANDATED BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Acupuncture Services		
Benefits are limited as follows: 10 visits per year	100% after you pay a $40 Copayment per visit.	50% after Deductible has been met.
Clinical Trials		
Participation in a qualifying clinical trial for the treatment of: Cancer Cardiovascular (cardiac/stroke) Surgical musculoskeletal disorders of the spine, hip and knees	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
	Pre-service Notification is required.	*Pre-service Notification is required.*
Dental Services - Inpatient		
Benefits are limited as follows: A child under seven years of age; Persons who are developmentally disabled, regardless of age; A person whose health is compromised and for whom general anesthesia is required, regardless of age.	70% after Deductible has been met.	50% after Deductible has been met.
	Pre-service Notification is required.	*Pre-service Notification is required.*
Diabetes Treatment		
Coverage for diabetes equipment and supplies, prescription items and diabetes self-management training programs when provided by or under the direction of a Physician.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
Infertility Services		
Benefits are limited as follows: $2,000 per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy.	70% after Deductible has been met.	50% after Deductible has been met.
	Pre-service Notification is required.	*Pre-service Notification is required.*
Mastectomy Services		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	

Types of Coverage	Network Benefits	Non-Network Benefits
Medical Foods		
Benefits are limited as follows: Formulas and special food products prescribed by a Physician for the treatment of phenylketonuria (PKU).	70% after Deductible has been met.	50% after Deductible has been met.
Mental Health and Substance Abuse (MH/SA) Services - Inpatient and Intermediate		
Benefits are limited as follows: 30 days per year	70% after Deductible has been met. *Prior Authorization is required from the MH/SA Designee.*	50% after Deductible has been met. *Prior Authorization is required from the MH/SA Designee.*
Mental Health and Substance Abuse (MH/SA) Services - Outpatient		
Benefits are limited as follows: 20 visits per year	50% after Deductible has been met. *Prior Authorization is required from the MH/SA Designee.*	50% after Deductible has been met. *Prior Authorization is required from the MH/SA Designee.*
Mental Health Services - Severe Mental Illness and Serious Emotional Disturbances		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary. *Pre-service Authorization is required.*	*Pre-service Authorization is required.*
Nicotine Use Benefit		
Benefits are limited as follows: $200 per person lifetime benefit maximum	100% after you pay a $40 Copayment per visit.	50% after Deductible has been met.
Orthotic Benefit		
	70% after Deductible has been met.	50% after Deductible has been met.
Osteoporosis Services		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
Prosthetic Devices - Laryngectomy		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	

Types of Coverage	Network Benefits	Non-Network Benefits
Specialized Footwear		
	70% after Deductible has been met.	50% after Deductible has been met.
Telemedicine Services		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
Temporomandibular Joint Disorder (TMJ) Services		
Benefits are limited as follows: Covered Services are payable in the same manner as surgery for other covered medical conditions except that benefits for treatment of TMJ are limited to $2,500 during the entire period of time you are covered under the Policy.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary. *Pre-service notification is required.*

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MEDICAL EXCLUSIONS

It is recommended that you review your COC 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, music, dance, 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 Chiropractic Treatment and 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 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 treatment 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. The following items are excluded, even if prescribed by a Physician: blood pressure cuff/monitor; enuresis alarm; home coagulation testing equipment; non-wearable external defibrillator; trusses; ultrasonic nebulizers; and ventricular assist devices. Devices and computers to assist in communication and speech except for speech aid prosthetics and tracheo-esophogeal voice prosthetics. 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 those needed to treat diabetes. This exclusion does not apply to medications which, due to their characteristics (as determined by us), 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. Growth hormone therapy.

Experimental, Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded (except Benefits provided for clinical trials for cancer and for Experimental or Investigational Services and Unproven Services as defined under Section 9: Defined Terms and except that coverage which is provided for an FDA-approved drug prescribed for a use that is different from the use for which the FDA approved it, when needed for treatment of a chronic and seriously debilitating or life-threatening condition. The drug must appear on the Formulary List, if applicable. The drug must be recognized for treatment of the condition for which the drug is being prescribed in one of the following established reference compendia: (1) U.S. Pharmacopoeia Dispensing Information; (2) American Medical Association's Drug Evaluation; or (3) American Hospital Formulary Service Drug Information, or it is recommended by two clinical studies or review articles in major peer reviewed professional journals. However, there is no coverage for any drug that the FDA or a major peer reviewed medical journal has determined to be contraindicated for the specific treatment for which the drug has been prescribed). 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 or subluxation of the foot. Shoes; shoe orthotics; shoe inserts and arch supports. This exclusion does not apply to shoes, shoe orthotics, shoe inserts or arch supports for which Benefits are provided as described under Specialized Footwear in Section 1 of the COC.

Medical Supplies

Prescribed or non-prescribed medical supplies and disposable supplies. Examples include: elastic stockings, ace bandages, gauze and dressings, urinary catheters. This exclusion does not apply to: Mastectomy Services, Prosthetic devices incident to laryngectomy as described in Section 1 of the COC,

- 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 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.

Mental Health / Substance Abuse

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 and Substance Abuse Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment, or crisis intervention. Mental Health Services as treatment for insomnia and other sleep disorders, neurological disorders and other disorders with a known physical basis. Treatment for conduct and impulse control disorders, personality disorders, paraphilias and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Abuse Designee. Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Mental Health/Substance Abuse Designee. Residential treatment services. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance abuse disorders that, in the reasonable judgment of the Mental Health/ Substance Abuse Designee, are any of the following:

- Not consistent with prevailing national standards of clinical practice for the treatment of such conditions.
- Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome.
- Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
- Not consistent with the Mental Health/Substance Abuse Designee's level of care guidelines or best practices as modified from time to time.

The Mental Health/Substance Abuse Designee may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.

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 and other nutritional and electrolyte supplements, including infant formula and donor breast milk, except as described under Medical Foods in Section 1 of the COC. 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).

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; car seats; chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners; electric scooters; 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; speech generating devices; treadmills; vehicle modifications such as van lifts; video players, whirlpools.

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 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). Breast reduction 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. 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. 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 disorders. Psychosurgery. Sex transformation operations. 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. Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury, dislocation, tumors or cancer, or as described in Temporomandibular Joint Disorder (TMJ) Services in Section 1 of the COC. Orthognathic surgery and jaw alignment, except as a treatment for obstructive sleep apnea. The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; dental restorations. Surgical and non-surgical treatment of obesity. Stand-alone multi-disciplinary smoking cessation programs

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. Foreign language and sign language interpreters.

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 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, but is not limited to, 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. If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness, or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected. 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.

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.

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 received from a Designated Facility or Designated Physician may be reimbursed at our discretion.

Types of Care

Multi-disciplinary pain management programs provided on an inpatient basis. Custodial care; domiciliary care. Private duty nursing. This means nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true: no skilled services are identified; skilled nursing resources are available in the facility; the skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose. Respite care; 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).

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 then 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 Person who meet the above coverage criteria, other then for malfunctions.

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. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when: required solely for purposes of career, school, sports or camp, travel, employment, insurance, marriage or adoption; related to judicial or administrative proceedings or orders; conducted for purposes of medical research; 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. 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. 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.

Preexisting Conditions (Applies only to groups of 50 or less employees)

Benefits for the treatment of a Preexisting Condition are excluded until the earlier of the following: The date you have had Continuous Creditable Coverage for 6 months. This exclusion does not apply to newborn children, newly adopted children or children placed for adoption. This exception for newborn, adopted children and children placed for adoption no longer applies after the end of the first 63-day period during which the child has not had Continuous Creditable Coverage.