UnitedHealthcare®
A UnitedHealth Group Company

Benefit Summary

ASO - Choice Plus
City of Hialeah Premier Medical Plan 2019
Employees, Sworn Police and Retirees Under 65
Traditional with Deductible - 25/750/90% Plan 7EK

UnitedHealthcare and City of Hialeah want to help you take control and make the most of your health care benefits. That's why we provide convenient services to get your health care questions answered quickly and accurately:

- Check personalized data: Find individualized information on your benefit coverage, check the status of claims, and search for physicians and hospitals using **www.myuhc.com**®.
- Researching health information: Find resources by logging on to www.myuhc.com.
- Get help: Contact Customer Care at the telephone number on the back of your ID card when you need assistance locating physicians and other health care professionals in your network, or when you have coverage or benefit questions.

PLAN HIGHLIGHTS

Types of Coverage	Network Benefits	Non-Network Benefits
Annual Deductible		
Individual Deductible	$750 per year	$1,250 per year
Family Deductible	$1,500 per year	$3,750 per year

> Member Copayments do not accumulate towards the Deductible.

Combined Medical and Pharmacy Out-of-Pocket Maximum		
Out-of-Pocket Maximum per Individual	$4,000 Individual per year $12,000 Family per year	$8,000 Individual per year $24,000 Family per year

> The Out-of-Pocket Maximum includes the Annual Deductible and Coinsurance.
> Member Copayments accumulate towards the Out-of-Pocket Maximum.
> Pharmacy cost share accumulates to the Out of Pocket Maximum.

Benefit Plan Coinsurance - The Amount the Plan Pays		
	90% after Deductible has been met.	70% after Deductible has been met.

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 Summary Plan Description (SPD), the SPD shall prevail. It is recommended that you review your SPD 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.

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Item#	Rev. Date	Benefit Accumulator
XXX-XXXX	0708	Calendar Year

Lifetime Maximum Benefit	
The maximum amount the Plan will pay during the entire period of time you are enrolled under the Plan.	Unlimited

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 Summary Plan Description.

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

BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Ambulance Service - Emergency and Non-Emergency		
Ground Ambulance	$75 copayment per transport	$75 copayment per transport.
Air Ambulance	$75 copayment per transport.	$75 copayment per transport.
	Prior Authorization is required for Non-Emergency Ambulance.	*Prior Authorization is required for Non-Emergency Ambulance.*
Cancer Resource Services (CRS)		
	90% after Deductible has been met. The Plan pays Benefits for oncology services provided by a Designated Facility in the CRS program. Call CRS toll-free at (866) 936-6002 or visit www.urncrs.com	Non-Network Benefits are not available

BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
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.	
	Prior Authorization is required.	*Prior Authorization is required.*
Congenital Heart Disease (CHD) Surgeries		
	90% after Deductible has been met.	70% after Deductible has been met. *Prior Authorization is required.*
Dental Services - Accident Only		
Benefits are limited as follows:	90% after Deductible has been met.	90% after Deductible has been met.
Oral Surgery/Wisdom Teeth:	*Prior Authorization is required.*	*Prior Authorization is required.*
Impacted tooth removal Maximum payable per tooth $50.00	90% after Deductible has been met.	70% after Deductible has been met.
Diabetes Services		
Diabetes Self Management and Training Diabetic Eye Examinations/Foot Care	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.	
Diabetes Self Management Items	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under Durable Medical Equipment and in the Outpatient Prescription Drug Section of the SPD.	
		Prior Authorization is required for Durable Medical Equipment and Diabetes Equipment in excess of $1,000.
Durable Medical Equipment (DME)		
	90% after Deductible has been met.	70% after Deductible has been met. *Prior Authorization is required for Durable Medical Equipment in excess of $1,000.*
Emergency Health Services - Outpatient		
	100% after you pay a $250 Copayment per visit.	100% after you pay a $250 Copayment per visit. *Prior Authorization is required if results in an Inpatient Stay.*

Types of Coverage	Network Benefits	Non-Network Benefits
Home Health Care		
Benefits are limited as follows: 60 visits per year	90% after Deductible has been met.	70% after Deductible has been met. *Prior Authorization is required.*
Hospice Care		
	90% after Deductible has been met.	70% after Deductible has been met. *Prior Authorization is required for Inpatient stays.*
Hospital - Inpatient Stay		
	90% after Deductible has been met.	70% after Deductible has been met. *Prior Authorization is required.*
Infertility Services		
Benefits are limited as follows: $5,000 per Covered Person during the entire period of time he or she is enrolled for coverage under the plan. In Vitro Fertilization (One procedure only)	90% after Deductible has been met. *Prior Authorization is required.*	70% after Deductible has been met. *Prior Authorization is required.*
Kidney Resource Services (KRS)		
	90% after Deductible has been met. The Plan pays Benefits for End Stage Renal Disease (ESRD) and chronic kidney disease provided by a Designated Facility in the KRS program. Call KRS toll-free at (888) 936-7246 and select the KRS prompt.	Non-Network Benefits are not available
Lab, X-Ray and Diagnostics - Outpatient		
(For Preventive Lab, X-Ray and Diagnostics, refer to the Preventive Care Services category.)	90% after Deductible has been met.	70% after Deductible has been met.
Lab, X-Ray and Major Diagnostics - CT, PET, MRI and Nuclear Medicine - Outpatient		
	90% after Deductible has been met.	70% after Deductible has been met.

BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Mental Health and Substance Abuse Services - Inpatient and Intermediate		
	90% after Deductible has been met. *Prior Authorization is required..*	70% after Deductible has been met. *Prior Authorization is required.*
Mental Health and Substance Abuse Services - Outpatient		
	100% after you pay a $25 Copayment per visit.	70% after Deductible has been met.
Ostomy Supplies		
	90% after Deductible has been met.	70% 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.	90% after Deductible has been met.	70% after Deductible has been met.
Physician Fees for Surgical and Medical Services		
	90% after Deductible has been met.	70% after Deductible has been met.
Physician's Office Services - Sickness and Injury		
Primary Physician Office Visit	100% after you pay a $25 Copayment per visit.	70% after Deductible has been met.
Specialist Physician Office Visit	100% after you pay a $50 Copayment per visit.	70% after Deductible has been met.

> **Only Office Visit Copayment** applies when these services are done during an office visit setting : CT, PET, MRI, Nuclear Medicine; Pharmaceutical Products; Scopic Procedures; Surgery; Therapeutic Treatments.

Types of Coverage	Network Benefits	Non-Network Benefits
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.	*Prior Authorization is required if the Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.*
Preventive Care Services		
Preventive Benefit Services as mandated by health care reform legislation:		
Primary Physician Office Visit	100%	70% after Deductible has been met.
Specialist Physician Office Visit	100%	70% after Deductible has been met.
Lab, X-Ray or other preventive tests	100%	70% after Deductible has been met
Private Duty Nursing – Outpatient		
	90% after Deductible has been met.	70% after Deductible has been met.
Prosthetic Devices		
	90% after Deductible has been met.	70% after Deductible has been met.
Rehabilitation Services - Outpatient Therapy and Chiropractic Treatment		
Benefits are limited as follows: Spinal Manipulation 25 visits per Calendar Year physical therapy- unlimited occupational therapy-unlimited speech therapy-unlimited (Includes coverage for non-restorative only for medical condition, not speech delay.) pulmonary rehabilitation-unlimited cardiac rehabilitation-unlimited post-cochlear implant aural therapy- unlimited Benefits for Habilitative Services are subject to the limits as stated in the benefits section.	90% after Deductible has been met.	70% after Deductible has been met. *Prior Authorization 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	90% after Deductible has been met.	70% after Deductible has been met.
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services		
Benefits are limited as follows: 60 days per year	90% after Deductible has been met.	70% after Deductible has been met. *Prior Authorization is required.*
Surgery - Outpatient		
	90% after Deductible has been met.	70% after Deductible has been met.
Temporomandibular Joint Services		
Must be medically Necessary.	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. *Prior Authorization is required.*	
Therapeutic Treatments - Outpatient		
Therapeutic treatments include, but are not limited to: Dialysis Intravenous chemotherapy or other intravenous infusion therapy Radiation oncology	90% after Deductible has been met.	70% after Deductible has been met. *Prior Authorization is required for certain services.*
Transplantation Services		
	90% after Deductible has been met. For Network Benefits, services must be received at a Designated Facility. *Prior Authorization is required.*	70% after Deductible has been met. *Prior Authorization is required.*
Travel and Lodging		
	Not covered	

BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Urgent Care Center Services		
> Only the Urgent Care Center Services Copayment applies when these services are done during an Urgent Care Center Services setting: CT, PET, MRI, Nuclear Medicine; Pharmaceutical Products; Scopic Procedures; Surgery; Therapeutic Treatments.	100% after you pay a $50 Copayment per visit.	70% after Deductible has been met.
Massotherapy		
$2,600 Calendar Year Maximum	100% after you pay a $25 Copayment per visit. *Prior Authorization is required*	70% after Deductible has been met. *Prior Authorization is required*
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. *Prior Authorization is required*	
Medical Supplies and Appliances		
Includes coverage for: Catheter Supplies Stockings/(Job/Compression) 2 pair per year Shoe Orthotics (based on Medical Necessity) Cranial Banding (based on Medical Necessity) Cochlear Implants (based on Medical Necessity)	90% after Deductible has been met.	70% after Deductible has been met
Nutritional Formula/Supplements		
Coverage is only available if this is the only source of nutrition.	90% after Deductible has been met.	70% after Deductible has been met

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MEDICAL EXCLUSIONS

It is recommended that you review your SPD 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; acupuncture; aromatherapy; hypnotism; rolfing (holistic tissue massage); 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 the SPD.

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 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 Plan as described in the SPD. 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. Diagnosis or treatment of or related to the teeth, jawbones or gums. Examples include: 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 the SPD. 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 the SPD. Dental braces (orthodontics). Treatment of congenitally missing (when the cells responsible for the formation of the tooth are absent from birth), malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly such as cleft lip or cleft palate.

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 some types of braces, including over-the-counter orthotic braces. 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. This exclusion does not apply to breast prosthesis, mastectomy bras and for which Benefits are provided as described under Reconstructive Procedures in the SPD.

Drugs

The exclusions listed below apply to the medical portion of the Plan only. Prescription Drug coverage is excluded under the medical plan because it is a separate benefit. Coverage may be available under the Prescription Drug portion of the Plan. See the SPD for coverage details and exclusions. Prescription drugs for outpatient use that are filled by a prescription order or refill. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by UnitedHealthcare), 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 or Unproven Services, unless the Plan has agreed to cover them as defined in the SPD. This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices or pharmacological regimens are the only available treatment options for your 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 the SPD.

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 the SPD or when needed for severe systemic disease. Cutting or removal of corns and calluses. Nail trimming, cutting, or debriding. Hygienic and preventive maintenance foot care; and other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot. 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.

Medical Supplies and Equipment

Prescribed or non-prescribed medical supplies and disposable supplies. Examples include: ace bandages, diabetic strips, and syringes; and ostomy bags and related supplies. 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 the SPD.
- Diabetic supplies for which Benefits are provided as described under Diabetes Services in the SPD.
- Ostomy bags and related supplies for which Benefits are provided as described under Ostomy Supplies in the SPD.

Tubings, nasal cannulas, connectors and masks, except when used with Durable Medical Equipment as described under Durable Medical Equipment as described in the SPD. The repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect and the replacement of lost or stolen Durable Medical Equipment and deodorants, filters, lubricants, tape, appliance clears, adhesive, or adhesive remover or other items that are not specifically identified in the SPD.

Mental Health / Substance Abuse

Inpatient, intermediate or outpatient care services that were not pre-authorized by the Mental Health/ Substance Abuse (MH/SA) Administrator; Services performed in connection with conditions not classified in the current edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. 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 (sexual behavior that is considered deviant or abnormal) 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 Administrator. Services utilizing methadone, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents as maintenance treatment for drug addiction. Treatment provided in connection with involuntary commitments, police detentions and other similar arrangements ,unless authorized by the Mental Health/Substance Abuse Administrator. Routine use of psychological testing without specific authorization; pastoral counseling. 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 Administrator, typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective, or are not consistent with:

- Prevailing national standards of clinical practice for the treatment of such conditions.
- Prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome.
- The Mental Health/Substance Abuse Administrator's level of care guidelines as modified from time to time.

The Mental Health/Substance Abuse Administrator 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. Services for the treatment of mental illness or mental health conditions and substance abuse services and chemical dependency services that City of Hialeah has elected to provide through a separate benefit Plan; and treatment provided in connection with involuntary commitments, police detentions and other similar arrangements,unless pre-authorized by the mental health/ substance abuse administrator.

Nutrition

Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy. Nutritional counseling for either individuals or groups except as defined under Nutritional Counseling in the SPD. Food of any kind. Foods that are not covered include: enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk unless they are the only source of nutrition; foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes; oral vitamins and minerals; meals you can order from a menu, for an additional charge, during an Inpatient Stay, and other dietary and electrolyte supplements; and health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

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 and humidifiers; batteries and battery chargers; breast pumps; car seats; chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners; electric scooters; exercise equipment and treadmills; home modifications to accommodate a health need such as ramps, swimming pools, elevators, handrails and stair glides; hot tubs; Jacuzzis, saunas and whirlpools; ergonomically correct chairs, non-Hospital beds, comfort beds, mattresses; medical alert systems; motorized beds; music devices; personal computers, pillows; power-operated vehicles; radios; saunas; strollers; safety equipment; vehicle modifications such as van lifts; and video players.

Physical Appearance

Cosmetic Procedures. See the definition in the SPD. 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; treatment of hair loss; varicose vein treatment of the lower extremities, when it is considered cosmetic; 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 intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Treatment of benign gynecomastia (abnormal breast enlargement in males). Breast reduction except as coverage is required by the Women's Health and Cancer Right's Act of 1998 for which Benefits are described under Reconstructive Procedures in the SPD. Breast reduction surgery that is determined to be a Cosmetic Procedure. This exclusion does not apply to breast reduction surgery which the Claims Administrator determines is requested to treat a physiologic functional impairment or to coverage required by the Women's Health and Cancer Right's Act of 1998 for which Benefits are described under Reconstructive Procedures in the SPD. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, health club memberships and programs, spa treatments 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, even if for morbid obesity. Wigs regardless of the reason for the hair loss.

Procedures and Treatments

Procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy. 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. Speech therapy to treat stuttering, stammering or other articulation disorders. Psychosurgery. 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. Chiropractic treatment to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain and improve function, such as asthma or allergies. Chiropractic treatment (the therapeutic application of chiropractic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function).Non-surgical treatment of obesity even if for morbid obesity. Surgical treatment of obesity even if there is a diagnosis of morbid obesity as described under Obesity Surgery in the SPD. Treatment of tobacco dependency. Chelation therapy, except to treat heavy metal poisoning.

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 ordered or delivered by a Christian Science practitioner. Services performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license. 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 in-vitro or services required to treat or correct underlying causes of infertility. The following infertility treatment-related services: cryo-preservation and other forms of preservation of reproductive materials, long-term storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue, and testicular tissue, donor services. 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. Health services and associated expenses for elective surgical, non-surgical, or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage).Contraceptive supplies and services. Fetal reduction surgery, except as described under Congenital Heart Disease (CHD) Surgeries in the SPD. Services provided by a doula (labor aide); and parenting, prenatal or birthing classes. Artificial reproduction treatments done for genetic or eugenic.

Services Provided under Another Plan

Health services for which other coverage is available under another plan, except for Eligible Expenses payable as described in the SPD. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation. If coverage under workers' compensation, no-fault automobile coverage or similar legislation is optional for you because you could elect it, or could have it elected for you. 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 as identified under Transplantation Services in the SPD. Mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available); and transplants that are not performed at a Designated Facility. This exclusion does not apply to cornea transplants; and donor costs for organ or tissue transplantation to another person (these contest may be payable through the recipient's benefit plan).

Travel

Health services provided in a foreign country, unless required as Emergency Health Services. Travel or transportation expenses, even if ordered by a Physician, except as identified under Travel and Lodging in the SPD. Additional travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at the Plan's discretion.

Types of Care

Multi-disciplinary pain management programs provided on an inpatient basis. Custodial care; domiciliary care. Private duty nursing received on an inpatient basis. 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 associated fitting charge for eye glasses and contact lenses. Routine vision examinations, including refractive examinations to determine the need for vision correction. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants). Purchase cost and associated fitting and testing charges for hearing aids, Bone Anchor Hearing Aids (BAHA) and all other hearing assistive devices. Eye exercise therapy. Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

All Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service – see the definition of Covered Health Services in the Glossary in the SPD. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when: required solely for purposes of career, education, school, sports or camp, travel, employment, insurance, marriage or adoption; or as a result of incarceration; 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 Plan 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 Plan 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 Plan. Charges that exceed Eligible Expenses or any specified limitation in the SPD. Health services when a provider waives the Copay,Annual Deductible or Coinsurance amounts. Autopsies and other coroner services and transportation services for a corpse. Charges for: missed appointments; room or facility reservations; completion of claim forms; or record processing. Charges prohibited by federal anti-kickback or self-referral status. Diagnostic tests that are: delivered in other than a Physician's office or health care facility; and self-administered home diagnostic tests, including but not limited to HIV and pregnancy tests. Vision therapy when rendered in connection with behavioral health disorders, including but not limited to: learning and reading disabilities; attention deficit/ hyperactively disorder; TBI; or dyslexia.

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Page 14 of 14