UnitedHealthcare Navigate

UnitedHealthcare of Illinois, Inc.

Schedule of Benefits

How Do You Access Benefits?

Selecting a Network Primary Care Physician

You must select a Network Primary Care Physician who is located in the geographic area of the permanent residence of the Subscriber, in order to obtain Benefits. In general health care terminology, a Primary Care Physician may also be referred to as a *PCP*. A Network Primary Care Physician will be able to coordinate all Covered Health Care Services and submit electronic referrals online to UnitedHealthcare of Illinois, Inc. for services from Network Physicians. If you are the custodial parent of an Enrolled Dependent child, you must select a Network Primary Care Physician who is located in the geographic area of the permanent residence of the Subscriber, for that child. If you do not select a Network Primary Care Physician for yourself or your Enrolled Dependent child, one will be assigned.

You may select any Network Primary Care Physician who is located in the geographic area of the permanent residence of the Subscriber and is accepting new patients. You may designate a Network Physician who specializes in pediatrics (including pediatric subspecialties, based on the scope of that provider's license under applicable state law) as the Network Primary Care Physician for an Enrolled Dependent child. For obstetrical or gynecological care, you do not need a referral from a Network Primary Care Physician and may seek care directly from any Network Physician who specializes in obstetrics or gynecology.

You can get a list of Network Primary Care Physicians, Network obstetricians and gynecologists and other Network providers through www.myuhc.com or the telephone number on your ID card.

You may change your Network Primary Care Physician by calling the telephone number shown on your ID card or by going to www.myuhc.com. Changes are permitted once per month. Changes submitted on or before the last day of the month will be effective on the first day of the following month.

Covered Health Care Services must be provided by or referred by your Primary Care Physician. If care from another Network Physician is needed, your Primary Care Physician will submit an electronic referral online to UnitedHealthcare of Illinois, Inc for services from that other Physician. The electronic referral must be received by UnitedHealthcare of Illinois, Inc. before the services are rendered. If you see a Network Physician without an electronic referral from your Primary Care Physician, you will be responsible for all charges and no Benefits will be paid, regardless of the place of service. This includes responsibility for charges for all related services and facility charges received from the Network Physician without the required referral. You should confirm what referrals have been submitted for you and the number of remaining visits on each referral by going to www.myuhc.com. You do not need a referral to see a Network obstetrician/gynecologist or to receive services through the Mental Health/Substance Use Disorders Delegate.

If you have a condition that requires ongoing care from a specialist physician or other health care provider, you may ask your Primary Care Physician for a standing referral to the specialist physician or other health care provider. As long as the condition requires ongoing services from the specialist physician, the standing referral will be effective for the period necessary to provide the referred services or one year, except in the event of termination of this Policy in which case rules for transition of services will apply, if applicable. Your Primary Care Physician may renew a standing referral as many times as necessary to treat your condition.

To obtain Benefits, you must receive Covered Health Care Services from a UnitedHealthcare Navigate Network provider. You can confirm that your provider is a UnitedHealthcare Navigate Network provider through the telephone number on your ID card or you can access a directory of providers at www.myuhc.com. You should confirm that your provider is a UnitedHealthcare Navigate Network provider, including when receiving Covered Health Care Services for which you received a referral from your Primary Care Physician.

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits*, Benefits are not available for services provided by out-of-Network providers. This Benefit plan does not provide an out-of-Network level of Benefits.

Benefits apply to Covered Health Care Services that are provided by a Network Physician or other Network provider.

Emergency Health Care Services provided by an out-of-Network provider will be reimbursed as set forth under *Allowed Amounts* as described at the end of this *Schedule of Benefits*.

Covered Health Care Services provided at certain Network facilities by an out-of-Network Physician, when not Emergency Health Care Services, will be reimbursed as set forth under *Allowed Amounts* as described at the end of this *Schedule of Benefits*. For these Covered Health Care Services, "certain Network facility" is limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

Ground and Air Ambulance transport provided by an out-of-Network provider will be reimbursed as set forth under *Allowed Amounts* as described at the end of this *Schedule of Benefits*.

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under a UnitedHealthcare of Illinois, Inc. Policy. As a result, they may bill you for the entire cost of the services you receive.

Additional information about the network of providers and how your Benefits may be affected appears at the end of this *Schedule of Benefits*.

If there is a conflict between this *Schedule of Benefits* and any summaries provided to you by the Group, this *Schedule of Benefits* will control.

Does Prior Authorization Apply?

We require prior authorization for certain Covered Health Care Services. Your Primary Care Physician and other Network providers are responsible for obtaining prior authorization before they provide these services to you.

Please note that prior authorization is required even if you have an electronic referral submitted online to UnitedHealthcare of Illinois, Inc. by your Primary Care Physician to seek care from another Network Physician.

We recommend that you confirm with us that all Covered Health Care Services have been prior authorized as required. Before receiving these services from a Network provider, you may want to call us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they do not prior authorize as required. You can call us at the telephone number on your ID card.

What Will You Pay for Covered Health Care Services?

Benefits for Covered Health Care Services are described in the tables below.

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Limits are calculated on a calendar year basis.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	Amounts
Annual Deductible	
The amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered Health Care Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. When a Covered Person was previously covered under a group policy that was replaced by the group Policy, any amount already applied to that annual deductible provision of the prior policy will apply to the Annual Deductible provision under the Policy. When the Group changes from a calendar year to a Policy year plan, any amount you pay for medical expenses in the last three months of the previous calendar year that is applied to the previous Annual Deductible, will be rolled over and applied to the current Policy year Annual Deductible. This roll-over feature applies only to the first Policy year. The amount that is applied to the Annual Deductible is calculated on the basis of the Allowed Amount or the Recognized Amount when applicable. The Annual Deductible does not include any amount that exceeds the Allowed Amount. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.	No Annual Deductible.
Out-of-Pocket Limit	
The maximum you pay per year for or Co-payments. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Limit does not include any of the following and, once the Out-of-Pocket Limit has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Care Services. • Charges that exceed Allowed Amounts, when applicable. • Co-payments for any Covered Health Care Service shown in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Limit.	$1,500 per Covered Person, not to exceed $3,000 for all Covered Persons in a family.

Co-payment

Co-payment is the amount you pay (calculated as a set dollar amount or percentage of the Allowed Amount or the Recognized Amount when applicable) each time you receive certain Covered Health Care Services. When Co-payments apply, the amount is listed on the following pages next to the description for each Covered Health Care Service.

Please note that for Covered Health Care Services, you are responsible for paying the lesser of:

- The applicable Co-payment.
- The Allowed Amount or the Recognized Amount when applicable.

Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.

Note: Referrals as described in this table must be submitted electronically by your Primary Care Physician before the service is rendered.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment You Pay? This May Include a Dollar Amount or Percentage.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
1. Ambulance Services			
In most cases, we will initiate and direct non-Emergency ambulance transportation.			
Emergency Ambulance Allowed Amounts for ground and Air Ambulance transport provided by an out-of-Network provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.	*Ground Ambulance* None *Air Ambulance* None	 Yes Yes	 No No
Non-Emergency Ambulance Ground or Air Ambulance, as appropriate. Allowed Amounts for Air Ambulance transport provided by an out-of-Network provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.	*Ground Ambulance* None *Air Ambulance* None	 Yes Yes	 No No
2. Cellular and Gene Therapy			
Cellular or Gene Therapy services must be received from a Designated Provider.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		
3. Clinical Trials			
Depending upon the Covered Health Care Service, Benefit limits are the same as those stated under the specific Benefit category in this	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule*		

Note: Referrals as described in this table must be submitted electronically by your Primary Care Physician before the service is rendered.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment You Pay? This May Include a Dollar Amount or Percentage.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Schedule of Benefits.	*of Benefits.*		
4. Congenital Heart Disease (CHD) Surgeries			
It is important that you notify us regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.			
Benefits under this section include only the inpatient facility charges for the CHD surgery. Depending upon where the Covered Health Care Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	$500 per Inpatient Stay to a maximum of $500 per Inpatient Stay for services provided with a referral to the admitting Network Specialist or other Network Physician from your Primary Care Physician	Yes	No
5. Dental Services - Accident Only			
	None	Yes	No
6. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care **Diabetes Self-Management Items** Benefits for diabetes equipment that meets the definition of DME are not subject to the limit stated under *Durable Medical Equipment (DME), Orthotics and Supplies.*	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		
7. Durable Medical Equipment (DME), Orthotics and Supplies			

Note: Referrals as described in this table must be submitted electronically by your Primary Care Physician before the service is rendered.			
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Covered Health Care Service	**What Is the Co-payment You Pay? This May Include a Dollar Amount or Percentage.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	None	Yes	No
8. Emergency Health Care Services - Outpatient			
Note: If you are confined in an out-of-Network Hospital after you receive outpatient Emergency Health Care Services, you must notify us within one business day or on the same day of admission if reasonably possible. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the out-of-Network Hospital after receiving notice of the date a transfer is medically appropriate, Benefits will not be provided. If you are admitted as an inpatient to a Hospital directly from the Emergency room, the Benefits provided as described under *Hospital - Inpatient Stay* will apply. You will not have to pay the Emergency Health Care Services Co-payment and/or deductible. Allowed Amounts for Emergency Health Care Services provided by an out-of-Network provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.	$150 per visit.	Yes	No
9. Enteral Nutrition			
	None	Yes	No
10. Fertility Preservation for Iatrogenic Infertility			

Note: Referrals as described in this table must be submitted electronically by your Primary Care Physician before the service is rendered.			
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Covered Health Care Service	**What Is the Co-payment You Pay? This May Include a Dollar Amount or Percentage.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	None	Yes	No
11. Gender Dysphoria			
It is important that you notify us as soon as the possibility of surgery arises. Your notification allows the opportunity for us to provide you with additional information and services that may be available to you and are designed to achieve the best outcomes for you.			
Limits for voice modification therapy and/or voice lessons will be the same as, and combined with, outpatient speech therapy limits as described under *Habilitative Services* and *Rehabilitation Services - Outpatient Therapy and Manipulative Treatment*.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		
12. Habilitative Services			
For Dependents under 19 years of age, no limits apply. For Covered Persons age 19 and over: Inpatient services are limited per year as follows: • Limits will be the same as, and combined with, those stated under *Skilled Nursing Facility/Inpatient Rehabilitation Services*.	*Inpatient* Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under *Hospital - Inpatient Stay* or *Skilled Nursing Facility/Inpatient Rehabilitation Services* in this *Schedule of Benefits.*		
Outpatient therapies: • Physical therapy. • Occupational therapy. • Manipulative Treatment. • Speech therapy. • Post-cochlear implant aural therapy.	*Outpatient* None for Manipulative Treatment services provided by a Network Specialist or other Network Physician with a referral from your	Yes	No

Note: Referrals as described in this table must be submitted electronically by your Primary Care Physician before the service is rendered.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment You Pay? This May Include a Dollar Amount or Percentage.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
• Cognitive therapy. For the above outpatient therapies: Limits will be the same as, and combined with, those stated under *Rehabilitation Services - Outpatient Therapy and Manipulative Treatment.* Visit limits for Treatment for Autism Spectrum Disorders for Enrolled Dependents under 21 years of age do not apply.	Primary Care Physician $25 per visit for all other habilitative services		
13. Hearing Aids			
Benefits are limited to one hearing instrument per hearing impaired ear every 24 months. Benefits include repairs and/or replacement of a hearing instrument when Medically Necessary.	None	Yes	No
14. Home Health Care			
For the administration of intravenous infusion, you must receive services from a provider we identify.	None	Yes	No
15. Hospice Care			
	None	Yes	No
16. Hospital - Inpatient Stay			
	$500 per Inpatient Stay to a maximum of $500 per Inpatient Stay for services provided with a referral to the admitting Network Specialist or other Network Physician	Yes	No

Note: Referrals as described in this table must be submitted electronically by your Primary Care Physician before the service is rendered.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment You Pay? This May Include a Dollar Amount or Percentage.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	from your Primary Care Physician		
17. Infertility Services			
Benefits for Assisted Reproductive Technology (ART) are limited to four oocyte retrievals per plan year; however, if a retrieval is followed by a live birth, two additional oocyte retrievals will be covered. Following the final oocyte retrieval, Benefits will be provided for one subsequent procedure to transfer the oocytes or sperm to the Covered Person.	None for services provided by a Network Specialist or other Network Physician with a referral from your Primary Care Physician or when services are provided by an obstetrician or gynecologist	Yes	No
18. Lab, X-Ray and Diagnostic - Outpatient			
Lab Testing - Outpatient **X-Ray and Other Diagnostic Testing - Outpatient**	None None	Yes Yes	No No
19. Major Diagnostic and Imaging - Outpatient			
	None	Yes	No
20. Mental Health Care and Substance Use Disorders Services			
	Inpatient $500 per day to a maximum of $500 per Inpatient Stay *Outpatient*	Yes	No

Note: Referrals as described in this table must be submitted electronically by your Primary Care Physician before the service is rendered.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment You Pay? This May Include a Dollar Amount or Percentage.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Outpatient Office Visit		
	$25 per visit	Yes	No
	Outpatient Other		
	Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Programs		
	None	Yes	No
	Intensive Behavioral Therapy		
	None	Yes	No
	All Other Outpatient Services such as Electro-Convulsive Treatment, Psychological Testing, Transcranial Magnetic Stimulation, and Medication Assisted Treatment		
	None	Yes	No
21. Obesity - Weight Loss Surgery			
It is important that you notify us regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule*		

Note: Referrals as described in this table must be submitted electronically by your Primary Care Physician before the service is rendered.			
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Covered Health Care Service	**What Is the Co-payment You Pay? This May Include a Dollar Amount or Percentage.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	of Benefits.		
22. Ostomy Supplies			
	None	Yes	No
23. Pharmaceutical Products - Outpatient			
Certain coupons, offers, assistance programs, or discounts *(Coupons)* from pharmaceutical manufacturers or an affiliate may reduce the costs of your Specialty Pharmaceutical Products. Your applicable deductible and/or Co-payment may vary when you use a *Coupon*. Contact www.myuhc.com or the telephone number on your ID card for an available list of Specialty Pharmaceutical Products and the applicable deductible and/or Co-payment.	None	Yes	No
24. Physician Fees for Surgical and Medical Services			
Allowed Amounts for Covered Health Care Services provided by an out-of-Network Physician in certain Network facilities will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.	None for services provided by your Primary Care Physician or by a Network obstetrician or gynecologist None for services provided by a Network Specialist or other Network Physician with a referral from your Primary Care Physician	Yes	No

Note: Referrals as described in this table must be submitted electronically by your Primary Care Physician before the service is rendered.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment You Pay? This May Include a Dollar Amount or Percentage.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
25. Physician's Office Services - Sickness and Injury			
Co-payments and any deductible for the following services also apply when the Covered Health Care Service is performed in a Physician's office: • Major diagnostic and nuclear medicine described under *Major Diagnostic and Imaging - Outpatient*. • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient*. • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*. • Outpatient surgery procedures described under *Surgery - Outpatient*. • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*. **Note:** When a test is performed or a sample is drawn in the Physician's office, lab, radiology/X-ray, or other diagnostic analysis or testing whether performed in or out of the Physician's office will apply additional cost sharing as described above.	**For Covered Persons under the age of 19:** None for services provided by your Primary Care Physician or by a Network obstetrician or gynecologist $35 per visit for services provided by a Network Specialist or other Network Physician with a referral from your Primary Care Physician **For Covered**	Yes	No

Note: Referrals as described in this table must be submitted electronically by your Primary Care Physician before the service is rendered.			
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Covered Health Care Service	**What Is the Co-payment You Pay? This May Include a Dollar Amount or Percentage.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Persons age 19 and older: $25 per visit for services provided by your Primary Care Physician or by a Network obstetrician or gynecologist $35 per visit for services provided by a Network Specialist or other Network Physician with a referral from your Primary Care Physician	Yes	No
26. Pregnancy - Maternity Services			
	Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		
27. Preimplantation Genetic Testing (PGT) and Related Services			
	None	Yes	No
28. Preventive Care Services			
Physician office services	None for services provided by your Primary Care Physician or by a Network obstetrician or gynecologist None for services provided by a Network Specialist or other Network	No	No

Note: Referrals as described in this table must be submitted electronically by your Primary Care Physician before the service is rendered.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment You Pay? This May Include a Dollar Amount or Percentage.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Lab, X-ray or other preventive tests **Breast pumps**	Physician with a referral from your Primary Care Physician None for services provided by your Primary Care Physician or by a Network obstetrician or gynecologist None for services provided by a Network Specialist or other Network Physician with a referral from your Primary Care Physician None	No No	No No
29. Prosthetic Devices			
	None	Yes	No
30. Reconstructive Procedures			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		
31. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment			
Limited per year as follows: • 60 visits of physical therapy for multiple sclerosis. • 60 visits for any combination of	None for Manipulative Treatment services provided by a Network Specialist or	Yes	No

Note: Referrals as described in this table must be submitted electronically by your Primary Care Physician before the service is rendered.			
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Covered Health Care Service	**What Is the Co-payment You Pay? This May Include a Dollar Amount or Percentage.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
physical therapy, occupational therapy and speech therapy. • 60 visits of pulmonary rehabilitation therapy. • 60 visits of cardiac rehabilitation therapy. • 60 visits of post-cochlear implant aural therapy. • 60 visits of cognitive rehabilitation therapy.	other Network Physician with a referral from your Primary Care Physician $25 per visit for all other rehabilitation services		
32. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	None for services provided by your Primary Care Physician or by a Network obstetrician or gynecologist None for services provided with a referral to the servicing Network Specialist or other Network Physician from your Primary Care Physician	Yes	No
33. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to: • Covered Health Care Services in a Skilled Nursing Facility are not subject to an annual limit.	$500 per day to a maximum of $500 per Inpatient Stay	Yes	No

Note: Referrals as described in this table must be submitted electronically by your Primary Care Physician before the service is rendered.			
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Covered Health Care Service	**What Is the Co-payment You Pay? This May Include a Dollar Amount or Percentage.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
• Covered Health Care Services in an Inpatient Rehabilitation Facility are not subject to an annual limit.			
34. Surgery - Outpatient			
	None for services provided by your Primary Care Physician or by a Network obstetrician or gynecologist None for services provided with a referral to the servicing Network Specialist or other Network Physician from your Primary Care Physician	Yes	No
35. Temporomandibular Joint (TMJ) and Craniomandibular Disorder (CMD) Services			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		
36. Therapeutic Treatments - Outpatient			
	None	Yes	No
37. Transplantation Services			
Transplantation services must be received from a Designated Provider. We do not require that cornea transplants be received from a	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule*		

Note: Referrals as described in this table must be submitted electronically by your Primary Care Physician before the service is rendered.			
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Covered Health Care Service	**What Is the Co-payment You Pay? This May Include a Dollar Amount or Percentage.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Designated Provider.	*of Benefits.*		
38. Urgent Care Center Services			
Co-payments and any deductible for the following services also apply when the Covered Health Care Service is performed at an Urgent Care Center: • Major diagnostic and nuclear medicine described under *Major Diagnostic and Imaging - Outpatient*. • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient*. • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*. • Outpatient surgery procedures described under *Surgery - Outpatient*. • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*.	$25 per visit	Yes	No
39. Urinary Catheters			
	None	Yes	No
40. Virtual Care Services			
Benefits are available only when services are delivered through a Designated Virtual Network Provider.	None	Yes	No

Note: Referrals as described in this table must be submitted electronically by your Primary Care Physician before the service is rendered.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment You Pay? This May Include a Dollar Amount or Percentage.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
You can find a Designated Virtual Network Provider by contacting us at www.myuhc.com or the telephone number on your ID card.			
41. Vision Exams			
Limited to 1 exam every 12 months.	None	Yes	No
42. Wigs			
Limited to one every 12 months.	None	Yes	No
Additional Benefits Required By Illinois Law			
43. Dental Services - Anesthesia and Facility			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
44. Examination and Treatment for Sexual Assault			
	None	Yes	No
45. Human Breast Milk			
	None	Yes	No
46. Jaw Care Services			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
47. Neuromuscular, Neurological, or Cognitive Impairment Treatment			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under		

Note: Referrals as described in this table must be submitted electronically by your Primary Care Physician before the service is rendered.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment You Pay? This May Include a Dollar Amount or Percentage.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	each Covered Health Care Service category in this *Schedule of Benefits.*		
48. Pediatric Palliative Care			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
49. Port-Wine Stain Treatment			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
50. Telehealth Services			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		

Section 1: Covered Health Care Services

When Are Benefits Available for Covered Health Care Services?

Benefits are available only when all of the following are true:

- The health care service, including supplies or Pharmaceutical Products, is only a Covered Health Care Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Care Service in *Section 9: Defined Terms*.)
- You receive Covered Health Care Services while the Policy is in effect.
- You receive Covered Health Care Services prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Health Care Services is a Covered Person and meets all eligibility rules specified in the Policy which includes this C*ertificate* and the Group *Application*.

The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Care Service under the Policy.

Benefits are available for services provided by a Network pharmacist who meets the requirements and scope of practice as set forth in the *Pharmacy Practice Act.* Services include pharmacy testing, screening, vaccinations, treatment services and patient care. Benefits for these services are provided to the same extent as services under the applicable Benefit category in this section unless otherwise specified in the *Schedule of Benefits*.

This section describes Covered Health Care Services for which Benefits are available. Please refer to the attached *Schedule of Benefits* for details about:

- The amount you must pay for these Covered Health Care Services (including any Annual Deductible, and/or Co-payment).
- Any limit that applies to these Covered Health Care Services (including visit, day and dollar limits on services).
- Any limit that applies to the portion of the Allowed Amount or the Recognized Amount when applicable, you are required to pay in a year (Out-of-Pocket Limit).
- Any responsibility you have for obtaining prior authorization or notifying us.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

1. Ambulance Services

Emergency ambulance transportation by a licensed ambulance service (either ground or Air Ambulance) to the nearest Hospital where the required Emergency Health Care Services can be performed.

Non-Emergency ambulance transportation by a licensed ambulance service (either ground or Air Ambulance, as appropriate) between facilities only when the transport meets one of the following:

- From an out-of-Network Hospital to the closest Network Hospital when Covered Health Care Services are required.
- To the closest Network Hospital that provides the required Covered Health Care Services that were not available at the original Hospital.

- From a short-term acute care facility to the closest Network long-term acute care facility (LTAC), Network Inpatient Rehabilitation Facility, or other Network sub-acute facility where the required Covered Health Care Services can be delivered.

For the purpose of this Benefit the following terms have the following meanings:

  - "Long-term acute care facility (LTAC)" means a facility or Hospital that provides care to people with complex medical needs requiring long-term Hospital stay in an acute or critical setting.
  - "Short-term acute care facility" means a facility or Hospital that provides care to people with medical needs requiring short-term Hospital stay in an acute or critical setting such as for recovery following a surgery, care following sudden Sickness, Injury, or flare-up of a chronic Sickness.
  - "Sub-acute facility" means a facility that provides intermediate care on short-term or long-term basis.

2. Cellular and Gene Therapy

Cellular Therapy and Gene Therapy received on an inpatient or outpatient basis at a Hospital or on an outpatient basis at an Alternate Facility or in a Physician's office.

Benefits for CAR-T therapy for malignancies are provided as described under *Transplantation Services*.

3. Clinical Trials

Routine patient care costs incurred while taking part in a qualifying clinical trial for the treatment of:

- Cancer or other life-threatening disease or condition. For purposes of this Benefit, a life-threatening disease or condition is one which is likely to cause death unless the course of the disease or condition is interrupted.
- Cardiovascular disease (cardiac/stroke) which is not life threatening, when the clinical trial meets the qualifying clinical trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, when the clinical trial meets the qualifying clinical trial criteria stated below.
- Other diseases or disorders which are not life threatening, when the clinical trial meets the qualifying clinical trial criteria stated below.

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from taking part in a qualifying clinical trial.

Benefits are available only when you are clinically eligible, as determined by the researcher, to take part in the qualifying clinical trial.

Routine patient care costs for qualifying clinical trials include:

- Covered Health Care Services for which Benefits are typically provided absent a clinical trial.
- Covered Health Care Services required solely for the following:
  - The provision of the Experimental or Investigational Service(s) or item.
  - The clinically appropriate monitoring of the effects of the service or item, or
  - The prevention of complications.
- Covered Health Care Services needed for reasonable and necessary care arising from the receipt of an Experimental or Investigational Service(s) or item.

Routine patient care costs for Qualifying Clinical Cancer Trials include:

- Covered Health Care Services provided in the Qualified Clinical Cancer Trial that are otherwise generally covered under the Policy.
- Covered Health Care Services consistent with the standard of care for the treatment of cancer, including the type and frequency of any diagnostic modality that a provider typically provides to a cancer patient who is not enrolled in a Qualified Clinical Cancer Trial.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service(s) or item. The only exceptions to this are:
  - Certain *Category B* devices.
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with our medical and drug policies.
- Items and services provided solely to meet data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that clearly does not meet widely accepted and established standards of care for a particular diagnosis.
- Items and services provided by the research sponsors free of charge for any person taking part in the trial.

Routine patient care costs for Qualifying Clinical Cancer Trials do not include:

- A health care service, item or drug that is the subject of the cancer clinical trial.
- A health care service, item or drug provided solely to satisfy data collection and analysis needs for the Qualified Clinical Cancer Trial that is not used in the direct clinical management of the patient.
- An investigational drug or device that has not been approved for market by the *U.S. Food and Drug Administration*.
- Transportation, lodging, food or other expenses for the patient, family member or companion of the patient that are associated with the travel to or from the facility providing the cancer clinical trial, unless the Policy covers these expenses for a cancer patient who is not enrolled in a Qualified Clinical Cancer Trial.
- A health care service, item, or drug customarily provided by the Qualified Clinical Cancer Trial sponsors free of charge for any patient.
- A health care service or item, which except for the fact that it is being provided in a Qualified Clinical Cancer Trial, is otherwise specifically excluded from coverage under the Policy, including:
  - Costs of extra treatments, services, procedures, tests, or drugs that would not be performed or administered except for the fact that you are participating in the cancer clinical trial; and
  - Costs of non-health care services that the patient is required to receive as the result of participation in the approved cancer clinical trial.
- Costs for services, items or drugs that are eligible for reimbursement from a source other than a patient's contract or policy providing for third-party payment or prepayment of health or medical expenses, including the sponsor of the approved cancer clinical trial.
- Costs associated with approved cancer clinical trials designed exclusively to test toxicity or disease pathophysiology, unless the Policy covers these expenses for a cancer patient who is not enrolled in a Qualified Clinical Cancer Trial.

- A health care service or item that is eligible for reimbursement by a source other than the Policy, including the sponsor of the Qualified Clinical Cancer Trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial. It takes place in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition. It meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease, musculoskeletal disorders of the spine, hip and knees and other diseases or disorders which are not life-threatening, a qualifying clinical trial is a Phase I, Phase II, or Phase III clinical trial. It takes place in relation to the detection or treatment of such non-life-threatening disease or disorder. It meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
    - *National Institutes of Health (NIH)*. (Includes *National Cancer Institute (NCI)*.)
    - *Centers for Disease Control and Prevention (CDC)*.
    - *Agency for Healthcare Research and Quality (AHRQ)*.
    - *Centers for Medicare and Medicaid Services (CMS)*.
    - A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA).*
    - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
    - The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* if the study or investigation has been reviewed and approved through a system of peer review. The peer review system is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
        - Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*.
        - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation takes place under an investigational new drug application reviewed by the *U.S. Food and Drug Administration*.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- The clinical trial must have a written protocol that describes a scientifically sound study. It must have been approved by all relevant institutional review boards (*IRBs*) before you are enrolled in the trial. We may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Care Service and is not otherwise excluded under the Policy.

4. Congenital Heart Disease (CHD) Surgeries

CHD surgeries which are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as:

- Coarctation of the aorta.
- Aortic stenosis.

- Tetralogy of Fallot.
- Transposition of the great vessels.
- Hypoplastic left or right heart syndrome.

Benefits include the facility charge and the charge for supplies and equipment. Benefits for Physician services are described under *Physician Fees for Surgical and Medical Services*.

Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

You can call us at the telephone number on your ID card for information about our specific guidelines regarding Benefits for CHD services.

5. Dental Services - Accident Only

Dental services, including dental ancillary services, when all of the following are true:

- Treatment is needed because of accidental damage.
- You receive dental services from a Doctor of Dental Surgery or Doctor of Medical Dentistry.
- The dental damage is severe enough that first contact with a Physician or dentist happened within 72 hours of the accident. (You may request this time period be longer if you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

Please note that dental damage that happens as a result of normal activities of daily living or extraordinary use of the teeth is not considered an accidental Injury. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

Dental services to repair damage caused by accidental Injury must follow these time-frames:

- Treatment is started within three months of the accident, or if not a Covered Person at the time of the accident, within the first three months of coverage under the Policy, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care).
- Treatment must be completed within 12 months of the accident, or if not a Covered Person at the time of the accident, within the first 12 months of coverage under the Policy.

Benefits for treatment of accidental Injury are limited to the following:

- Emergency exam.
- Diagnostic X-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to Injury with implant, dentures or bridges.

6. Diabetes Services

Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care

Outpatient self-management training for the treatment of diabetes, including medical nutrition therapy services and education programs that allow the patient to maintain an A1c level within the range identified in nationally recognized standards of care. Services must be ordered by a Physician and provided by appropriately licensed or registered health care professionals.

Benefits also include medical eye exams (dilated retinal exams) and preventive foot care for diabetes.

Diabetic Self-Management Items

Insulin pumps and supplies, blood glucose monitors for the legally blind, and cartridges for the legally blind for the management and treatment of diabetes, based upon your medical needs. An insulin pump is subject to all the conditions of coverage stated under *Durable Medical Equipment (DME), Orthotics and Supplies*. Benefits for blood glucose meters including continuous glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets, lancets and lancet devices, glucagon emergency kits, and *FDA*-approved oral agents used to control blood sugar are described under *Section 11: Outpatient Prescription Drugs*.

7. Durable Medical Equipment (DME), Orthotics and Supplies

Benefits are provided for DME and certain orthotics and supplies. If more than one item can meet your functional needs, Benefits are available only for the item that meets the minimum specifications for your needs. If you purchase an item that exceeds these minimum specifications, we will pay only the amount that we would have paid for the item that meets the minimum specifications, and you will be responsible for paying any difference in cost.

DME and Supplies

Examples of DME and supplies include:

- Equipment to help mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Negative pressure wound therapy pumps (wound vacuums).
- Mechanical equipment needed for the treatment of long term or sudden respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related needed supplies as described under *Diabetes Services*.
- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this *Certificate*.
- Compression sleeves when Medically Necessary to prevent or mitigate lymphedema.

Benefits include lymphedema stockings for the arm as required by the *Women's Health and Cancer Rights Act of 1998.*

Benefits also include dedicated speech generating devices and tracheo-esophageal voice devices required for treatment of severe speech impairment or lack of speech directly due to Sickness or Injury. Benefits for the purchase of these devices are available only after completing a required three-month rental period. Benefits are limited as stated in the *Schedule of Benefits*.

Orthotics and Customized Orthotic Devices

Orthotic braces, including needed changes to shoes to fit braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are a Covered Health Care Service.

We will decide if the equipment should be purchased or rented.

Benefits are available for repairs and replacement, except as described in *Section 2: Exclusions and Limitations,* under *Medical Supplies and Equipment.*

These Benefits apply to external DME. Unless otherwise excluded, items that are fully implanted into the body are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Service categories in this *Certificate*.

8. Emergency Health Care Services - Outpatient

Services that are required to stabilize or begin treatment in an Emergency. Emergency Health Care Services must be received on an outpatient basis at a Hospital or Alternate Facility.

Benefits include the facility charge, supplies and all professional services required to stabilize your condition and/or begin treatment. This includes placement in an observation bed to monitor your condition (rather than being admitted to a Hospital for an Inpatient Stay).

9. Enteral Nutrition

Benefits are provided for specialized enteral formulas administered either orally or by tube feeding for certain conditions under the direction of a Physician. An example includes:

- Amino acid-based elemental formulas for the diagnosis and treatment of:
  - Eosinophilic Disorders.
  - Short bowel syndrome.

10. Fertility Preservation for Iatrogenic Infertility

Benefits are available for fertility preservation for medical reasons that cause irreversible Infertility such as chemotherapy, radiation treatment, and bilateral oophorectomy due to cancer. Services include the following procedures, when provided by or under the care or supervision of a Physician:

- Collection of sperm.
- Cryo-preservation of sperm.
- Ovarian stimulation, retrieval of eggs and fertilization.
- Oocyte cryo-preservation.
- Embryo cryo-preservation.

Benefits for medications related to the treatment of fertility preservation are provided as described under *Section 11: Outpatient Prescription Drugs* or under *Pharmaceutical Products - Outpatient* in this section.

Benefits are not available for elective fertility preservation.

Benefits are not available for embryo transfer.

Benefits are not available for long-term storage costs (greater than one year).

11. Gender Dysphoria

Benefits for the treatment of gender dysphoria provided by or under the direction of a Physician.

For the purpose of this Benefit, "gender dysphoria" is a disorder characterized by the specific diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders published by* the *American Psychiatric Association*.

12. Habilitative Services

For purposes of this Benefit, "habilitative services" means Skilled Care services that are part of a prescribed plan of treatment to help a person with a disabling condition, or children with congenital, genetic, or early acquired disorders to learn or improve skills and functioning for daily living. Benefits will be determined by reviewing both the skilled nature of the service and the need for Physician-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services.

Habilitative services are limited to:

- Physical therapy.
- Occupational therapy.
- Manipulative Treatment.
- Speech therapy.
- Post-cochlear implant aural therapy.
- Cognitive therapy.
- Treatment for Autism Spectrum Disorders for Enrolled Dependents under 21 years of age.

Benefits are provided for habilitative services for both inpatient services and outpatient therapy when you have a disabling condition when both of the following conditions are met:

- Treatment is administered by any of the following:
  - Licensed speech-language pathologist.
  - Licensed audiologist.
  - Licensed occupational therapist.
  - Licensed physical therapist.
  - Physician.
- Treatment must not be Experimental or Investigational.

The following are not habilitative services:

- Custodial Care.
- Respite care.
- Day care.
- Therapeutic recreation.
- Educational/Vocational training.
- Residential Treatment.
- A service or Treatment Plan that does not help you meet functional goals.
- Services solely educational in nature.
- Educational services otherwise paid under state or federal law.

We may require the following be provided:

- Medical records.
- Other necessary data to allow us to prove that medical treatment is needed.

When the treating provider expects that continued treatment is or will be required to allow you to achieve progress, we may request additional medical records.

Benefits will not be denied based on the location of where the Medically Necessary services are provided, however your cost share may vary depending on whether you receive inpatient or outpatient services.

Habilitative services provided in your home by a Home Health Agency are provided as described under *Home Health Care*. Habilitative services provided in your home other than by a Home Health Agency are provided as described under this section.

Benefits for DME and prosthetic devices, when used as a part of habilitative services, are described under *Durable Medical Equipment (DME), Orthotics and Supplies* and *Prosthetic Devices.*

13. Hearing Aids

Hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). These are electronic amplifying devices designed to bring sound more effectively into the ear. These consist of a microphone, amplifier and receiver.

Benefits are available for a hearing instrument or hearing aid that is purchased through a licensed audiologist, hearing aid dispenser, otolaryngologist, or other authorized provider. Benefits are provided for the hearing instrument or hearing aid and related services, including audiological exams and selection, fitting, and adjustment of ear molds to maintain optimal fit.

Hearing instruments or hearing aids include any instrument or device designed, intended, or offered for the purpose of improving a person's hearing and any parts, attachments, or accessories, including an ear mold but excluding batteries and cords.

If more than one type of hearing aid can meet your functional needs, Benefits are available only for the hearing aid that meets the minimum specifications for your needs. If you purchase a hearing aid that exceeds these minimum specifications, we will pay only the amount that we would have paid for the hearing aid that meets the minimum specifications, and you will be responsible for paying any difference in cost.

For hearing instruments or hearing aids that are purchased through an authorized provider, Benefits are available without a dollar maximum for Covered Persons of all ages and limited to one hearing instrument per hearing impaired ear every two years.

Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this *Certificate*.

Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Services categories in this *Certificate*. They are only available if you have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals prevent the use of a wearable hearing aid.
- Hearing loss severe enough that it would not be remedied by a wearable hearing aid.

14. Home Health Care

Services received from a Home Health Agency that are all of the following:

- Ordered by a Physician.
- Provided in your home by a registered nurse, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.
- Provided on a part-time, Intermittent Care schedule.

- Provided when Skilled Care is required.

To determine the availability of Benefits, both the skilled nature of the service and the need for Physician-directed medical management will be reviewed.

15. Hospice Care

Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. It includes the following:

- Short-term grief counseling for immediate family members while you are receiving hospice care.
- Coordinated home care.
- Medical supplies and dressings.
- Medication.
- Nursing services - skilled and non-skilled.
- Occupational therapy.
- Pain management services.
- Physical therapy.
- Physician visits.
- Psychological.
- Social and spiritual services.
- Respite care services.

Benefits are available when you receive hospice care from a licensed hospice agency.

You can call us at the telephone number on your ID card for information about our guidelines for hospice care.

16. Hospital - Inpatient Stay

Services and supplies provided during an Inpatient Stay in a Hospital.

Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)
- A stay following a covered mastectomy for the length of time determined as medically appropriate by the attending Physician and in accordance with protocols and guidelines based on sound scientific evidence and upon evaluation of the Covered Person and the availability of a post-discharge Physician's office visit or in-home nurse visit to verify the condition of the Covered Person in the first 48 hours after discharge.

17. Infertility Services

Coverage is provided for the diagnosis and treatment of Infertility, including:

- In vitro fertilization (IVF).

- Uterine embryo lavage.
- Embryo transfer.
- Artificial insemination.
- Gamete intrafallopian tube transfer (GIFT).
- Zygote intrafallopian tube transfer (ZIFT).
- Low tubal ovum transfer.

The coverage provided above is subject to the following conditions:

Benefits are provided for IVF, GIFT, or ZIFT procedures only if:

- The Covered Person has been unable to attain or maintain a viable Pregnancy, or sustain a successful Pregnancy through reasonable, less costly, medically appropriate Infertility treatments for which coverage is available under the Policy; and
- The procedures are performed at facilities conforming to *The American College of Obstetricians and Gynecologists* guidelines for in vitro fertilization clinics or to the *American Fertility Society* minimal standards for programs of in vitro fertilization.

Benefits for Assisted Reproductive Technology (ART) are limited to four oocyte retrievals per plan year; however, if a retrieval is followed by a live birth, two additional oocyte retrievals will be covered. Following the final oocyte retrieval, Benefits will be provided for one subsequent procedure to transfer the oocytes or sperm to the Covered Person or to a Surrogate.

Benefits do not include any of the following:

- Non-medical costs of a donor or a Surrogate.
- Travel costs for travel within 100 miles of the Covered Person's home address, travel costs not necessary, not mandated or required by us.
- Infertility treatments deemed experimental in nature. However, when Infertility treatment includes elements which are not experimental in nature along with those which are, to the extent services may be separately charged, those services which are not experimental in nature will be considered a Covered Health Care Service.
- Services provided to the Surrogate after the Surrogate has been discharged to regular obstetrical care.
- Non-medical expenses incurred by the Covered Person in order to contract with the Surrogate.
- Any other services rendered to a Surrogate that are not directly related to treatment of the Covered Person's Infertility.

Donor Expenses

Benefits include medical expenses of a donor for procedures to retrieve oocytes or sperm, and the subsequent procedure used to transfer the oocytes or sperm to the Covered Person or to the Surrogate. Associated donor medical expenses, including but not limited to physical exam, laboratory screening, psychological screening, and prescription drugs, will also be covered if established as prerequisites to donation by us.

Coverage will not be excluded for a known donor. In the event the Covered Person does not have arrangements with a known donor, we may require the use of a contracted facility. If the Covered Person uses a known donor, we may require the use of contracted providers by the donor for all medical treatment, including, but not limited to, testing, prescription drug therapy and ART procedures, if Benefits are dependent upon the use of such contracted providers.

Certain Benefits for *Infertility Services* may be excluded from coverage if your Group has identified itself as a religious institution or organization and the procedures listed above violate its religious and moral teachings and beliefs. Please contact us at www.myuhc.com or the telephone number on your ID card to verify your Infertility coverage.

18. Lab, X-Ray and Diagnostic - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital, Alternate Facility, or in a Physician's office include:

- Lab and radiology/X-ray.
- Mammography.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)
- Genetic Testing ordered by a Physician which results in available medical treatment options following Genetic Counseling.
- Presumptive Drug Tests and Definitive Drug Tests.
- Allergy testing.
- Diagnostic mammography, which includes a screening that is designed to evaluate an abnormality in a breast, including an abnormality seen or suspected on a screening mammogram or a subjective or objective abnormality otherwise detected in the breast. Benefits are available without cost share.
- Bone density tests including bone mass measurements for the diagnosis and treatment of osteoporosis for Covered Persons of any age.
- Cardiopulmonary monitors for a Covered Person who has had a cardiopulmonary event.
- Biomarker testing for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a disease or condition when the test is supported by medical and scientific evidence.
- Vitamin D testing in accordance with vitamin D deficiency risk factors identified by the *United States Centers for Disease Control and Prevention*.
- Comprehensive cancer testing and testing of blood or constitutional tissue for cancer predisposition testing determined to be Medically Necessary by a Physician licensed to practice medicine in all its branches.
- Liver disease screenings, including liver ultrasounds and alpha-fetoprotein blood tests, every six months for Covered Persons 35 years of age or older and under the age of 65 at high risk for liver disease. Benefits are available without cost share.
- Home saliva cancer screening, an outpatient test that utilizes saliva to detect biomarkers for early-stage cancer, every 24 months if the Covered Person:
    - Is asymptomatic and at high risk for the disease being tested for; or
    - Demonstrates symptoms for the disease being tested for at a physical exam.

Preventive screenings included in the comprehensive guidelines supported by the *Health Resources and Services Administration* are described under *Preventive Care Services*.

Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services*.

CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Major Diagnostic and Imaging - Outpatient*.

Please refer to your *Schedule of Benefits* under *Physician's Office Services - Sickness and Injury* for how cost shares (Co-payment and/or deductible as applicable) apply, when services are provided in a Physician's office.

19. Major Diagnostic and Imaging - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services received on an outpatient basis at a Hospital, Alternate Facility, or in a Physician's office.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)
- Medically Necessary pancreatic cancer screenings.

Please refer to your *Schedule of Benefits* under *Physician's Office Services - Sickness and Injury* for how cost shares (Co-payment and/or deductible as applicable) apply, when services are provided in a Physician's office.

20. Mental Health Care and Substance Use Disorders Services

The Mental Health/Substance Use Disorders Delegate (the Delegate) administers Benefits for Mental Health and Substance Use Disorders Services. If you need assistance with coordination of care, locating a provider, and confirmation that services you plan to receive are Covered Health Care Services, you can contact the Delegate at the telephone number on your ID card.

Mental Health Care and Substance Use Disorders (also referred to as substance-related and addictive disorders) Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility or in a provider's office. All services must be provided by or under the direction of a behavioral health provider who is properly licensed and qualified by law and acting within the scope of their licensure.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment/High Intensity Outpatient.
- Intensive Outpatient Programs.
- Outpatient treatment.

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment and treatment, and/or procedures.
- Medication management.
- Individual, family, and group therapy.
- Crisis intervention.
- Psychological testing.

- Neuropsychological testing.
- Electroconvulsive therapy.
- Detoxification programs.
- Acute treatment services.
- Clinical stabilization services.
- Mental Health Care Services, including Diagnosis of Autism Spectrum Disorders and Treatment for Autism Spectrum Disorders (including Intensive Behavioral Therapies such as *Applied Behavior Analysis (ABA))* that are the following:
    - Focused on the treatment of core deficits of Autism Spectrum Disorder.
    - Provided by a *Board Certified Behavior Analyst (BCBA)* or other qualified provider under the appropriate supervision.
    - Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.

    This section describes only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Care Service for which Benefits are available under the applicable medical Covered Health Care Services categories in this *Certificate*.
- Benefits delivered through the psychiatric Collaborative Care Model.

    The term "psychiatric Collaborative Care Model" means the evidence-based, integrated behavioral health service delivery method, which includes a formal collaborative arrangement among a primary care team consisting of a primary care provider, a care manager, and a psychiatric consultant, and includes, but is not limited to, the following elements:
    - Care directed by the primary care team;
    - Structured care management;
    - Regular assessments of clinical status using validated tools; and
    - Modification of treatment as appropriate.
- Treatment models for serious mental illness in a child or young adult under age 26. Coverage includes the following bundled, evidence-based treatment:
    - Coordinated specialty care for first episode psychosis treatment, covering the elements of the treatment model included in the most recent national research trials conducted by the National Institute of Mental Health in the Recovery After an Initial Schizophrenia Episode (RAISE) trials for psychosis resulting from a serious mental illness, but excluding the components of the treatment model related to education and employment support.
    - Assertive Community Treatment (ACT) and Community Support Team (CST) treatment.
- One annual mental health prevention and wellness visit.
    - The visit may include:
        - Any age-appropriate screening for purposes of identifying a mental health issue, condition, or disorder.
        - Discussion of mental health symptoms, including symptoms of a previously diagnosed mental health condition or disorder.
        - Performance of an evaluation of adverse childhood experiences.

- Discussion of mental health and wellness.

- The visit will be covered up to 60 minutes and performed by a physician licensed to practice medicine in all of its branches, a licensed clinical psychologist, a licensed clinical social worker, a licensed clinical professional counselor, a licensed marriage and family therapist, a licensed social worker, or a licensed professional counselor.

Benefits for a mental health prevention and wellness visit are available without cost share.

21. Obesity - Weight Loss Surgery

Surgical treatment of obesity when provided by or under the direction of a Physician when either of the following criteria is met:

- You have a body mass index (BMI) of greater than 40.
- You have a body mass index (BMI) of greater than 35 with complicating coexisting medical conditions or diseases (such as sleep apnea or diabetes) directly related to, or made worse by, obesity.

22. Ostomy Supplies

Benefits for ostomy supplies are limited to the following:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

23. Pharmaceutical Products - Outpatient

Pharmaceutical Products for Covered Health Care Services administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in your home. Pharmaceutical Products include breast cancer pain medications.

Benefits are available for treatment with immune gamma globulin therapy when diagnosed with a primary immunodeficiency and prescribed as Medically Necessary by a Physician.

Benefits include the use of intravenous immunoglobulin therapy for the treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and pediatric acute onset neuropsychiatric syndrome (PANS).

Benefits include long-term antibiotic therapy for tick-borne diseases. Long-term antibiotic therapy includes the administration of oral, intramuscular, or intravenous antibiotics singly or in combination for periods of time in excess of four weeks. Necessary office visits and ongoing testing related to tick-borne diseases are Covered Health Care Services for which Benefits are available under the applicable Covered Health Care Services categories in this *Certificate.*

Benefits are provided for Pharmaceutical Products which, due to their traits, are administered or directly supervised by a qualified provider or licensed/certified health professional. Depending on where the Pharmaceutical Product is administered, Benefits will be provided for administration of the Pharmaceutical Product under the corresponding Benefit category in this *Certificate*.

Benefits for medication normally available by a prescription or order or refill are provided as described under *Section 11: Outpatient Prescription Drugs.*

If you require certain Pharmaceutical Products, including Specialty Pharmaceutical Products, we may direct you to a Designated Dispensing Entity. Such Designated Dispensing Entities may include an

outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

If you/your provider are directed to a Designated Dispensing Entity and you/your provider choose not to get your Pharmaceutical Product from a Designated Dispensing Entity, you/your provider may contact us, and we will assist you/your provider in selecting another specialty pharmacy to obtain your Pharmaceutical Product.

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you must use a different Pharmaceutical Product(s) and/or prescription drug product(s) for which Benefits are provided as described under *Section 11: Outpatient Prescription Drugs* first. You may find out whether a particular Pharmaceutical Product is subject to step therapy requirements by contacting us at www.myuhc.com or the telephone number on your ID card.

Certain Specialty Pharmaceutical Products are eligible for coupons, offers, assistance programs, or discounts (*Coupons*) from pharmaceutical manufacturers or affiliates that may reduce the cost for your Specialty Pharmaceutical Product. We may help you determine whether your Specialty Pharmaceutical Product is eligible for this reduction. If you are eligible and redeem a *Coupon* from a pharmaceutical manufacturer or affiliate, your applicable deductible and/or Co-payment may vary (*Adjusted Variable Co-payment*) and will be reflected as deductible and/or Co-payment in your Explanation of Benefits. Our payment will be determined based on the difference between the Allowed Amount minus the *Adjusted Variable Co-payment* described above. The redeemed Coupon value will not count toward any applicable deductible or Out-of-Pocket Limits. Please contact www.myuhc.com or the telephone number on your ID card for an available list of Specialty Pharmaceutical Drug Products. If you choose not to participate, you will pay the applicable deductible and/or Co-payment as described in the *Schedule of Benefits*.

We may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs by contacting us at www.myuhc.com or the telephone number on your ID card.

24. Physician Fees for Surgical and Medical Services

Physician fees for surgical procedures and other medical services received on an outpatient or inpatient basis in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls.

25. Physician's Office Services - Sickness and Injury

Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided regardless of whether the Physician's office is freestanding, located in a clinic or located in a Hospital.

Covered Health Care Services include medical education services that are provided in a Physician's office by appropriately licensed or registered health care professionals when both of the following are true:

- Education is required for a disease in which patient self-management is a part of treatment.
- There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

Covered Health Care Services include:

- Genetic Counseling.
- Allergy injections.
- Clinical breast exams:

  - At least every three years for women between the ages of 20 and 40.
  - Annually for women age 40 and older.
- Treatment for fibrocystic breast condition in the absence of a breast biopsy demonstrating an increased disposition to the development of breast cancer unless medical history is able to confirm a chronic, relapsing, symptomatic breast condition.
- Treatment for breast cancer Pain Therapy. Medically Necessary breast cancer pain medication is covered under *Pharmaceutical Products - Outpatient* or *Section 11: Outpatient Prescription Drugs*.
- Treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and pediatric acute onset neuropsychiatric syndrome (PANS), including, but not limited to, the use of intravenous immunoglobulin therapy. Benefits for intravenous immunoglobulin therapy are described under *Pharmaceutical Products - Outpatient*.
- Additional surgical opinion following a recommendation for elective surgery. Benefits will be limited to one consultation and related diagnostic services by a Physician.
- One annual office visit for a whole body skin examination for lesions suspicious for skin cancer. Benefits are available without cost share.

Covered Health Care Services for preventive care provided in a Physician's office are described under *Preventive Care Services*.

26. Pregnancy - Maternity Services

Benefits for Pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery and any related complications. Benefits are available for abortion care services without waiting periods, and the plan will not impose restrictions or delays of coverage.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Care Services include related tests and treatment.

If you are experiencing a high-risk Pregnancy, a case management program is available to assist you during your Pregnancy. You may contact us at www.myuhc.com or the telephone number on your ID card for additional information about this program.

Benefits are available if you are experiencing a mental, emotional, nervous, or substance use disorder or condition related to Pregnancy or postpartum complications. Benefits for these services are described under *Mental Health Care and Substance Use Disorders Services*.

Benefits include prenatal HIV testing when ordered by an attending Physician, a physician assistant, or an advanced practice registered nurse. Orders must be consistent with the recommendations of the *American College of Obstetricians and Gynecologists* or the *American Academy of Pediatrics*.

We will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a normal vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames. An earlier discharge may be provided if based on evaluation and availability of a post-discharge Physician office visit or an in-home nurse visit to verify the condition of the newborn in the first 48 hours after discharge. A shorter length stay must meet the protocols and guidelines for the length of a Hospital Inpatient Stay as developed by the *American College of Obstetricians and Gynecologists* or the *American Academy of Pediatrics*.

If the newborn child needs treatment for a Sickness, Injury, Congenital Anomaly or a premature birth, Benefits will be available for that care from the moment of birth. Please refer to *Section 3: When Coverage Begins* for additional information on adding your newborn to the Policy.

27. Preimplantation Genetic Testing (PGT) and Related Services

Preimplantation Genetic Testing (PGT) performed to identify and to prevent genetic medical conditions from being passed onto offspring. To be eligible for Benefits the following must be met:

- PGT must be ordered by a Physician after Genetic Counseling.
- The genetic medical condition, if passed onto offspring, would result in significant health problems or severe disability and be caused by a single gene (detectable by PGT-M) or structural changes of a parents' chromosome (detectable by PGT-SR).
- Benefits are limited to PGT for the specific genetic disorder and the following related services when provided by or under the supervision of a Physician:
  - Ovulation induction (or controlled ovarian stimulation).
  - Egg retrieval, fertilization and embryo culture.
  - Embryo biopsy.
  - Embryo transfer.
  - Cryo-preservation and short-term embryo storage (less than one year).

Benefits are not available for long-term storage costs (greater than one year).

28. Preventive Care Services

Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force (USPSTF).*
- Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.*
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

  Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include one breast pump per Pregnancy in conjunction with childbirth. Benefits include coverage for a personal-use electric breast pump. Breast pumps must be ordered by or provided by a Physician. You can find more information on how to access Benefits for breast pumps by contacting us at www.myuhc.com or the telephone number on your ID card.

  If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. Benefits are determined based on the following:

  - Which pump is the most cost effective.
  - Whether the pump should be purchased or rented (and the duration of any rental).

- Timing of purchase or rental.

The preventive care services described in this section may change as the *United States Preventive Services Task Force*, the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*, and the *Health Resources and Services Administration* guidelines are modified. You may access more information and details about coverage of these preventive health care services by contacting us at www.myuhc.com or the telephone number on your ID card.

Preventive health care services for adults

Benefits under this section include the following when required by federal law:

- Abdominal aortic aneurysm one-time screening for men of specified ages who have ever smoked.
- Alcohol misuse screening and counseling.
- Aspirin use counseling to prevent cardiovascular disease for men and women of certain ages.
- Blood pressure screening for all adults.
- Cholesterol screening for adults ages 40 to 75 years.
- Colorectal cancer screening for adults starting at age 50 years and continuing until age 75 years.
- Depression screening for adults.
- Diabetes (Type 2) screening for adults ages 40 to 70 years who are overweight or obese.
- Diet counseling for adults at higher risk for chronic disease.
- Falls prevention using exercise interventions in community-dwelling adults 65 years or older who are at increased risk for falls.
- Hepatitis B screening for adults at high risk.
- Hepatitis C virus infection screening for adults at high risk and adults born between 1945 and 1965.
- HIV screening for persons ages 15 to 65, and other ages at increased risk.
- Immunization vaccines for adults - doses, recommended ages, and recommended populations vary:
    - Haemophilus influenzae type b (HIB): 1 or 3 doses for at risk adults at any age depending on indication.
    - Hepatitis A.
    - Hepatitis B.
    - Herpes zoster (shingles).
    - Human papillomavirus (HPV).
    - Influenza (flu shot).
    - Measles, Mumps, Rubella.
    - Meningococcal.
    - Pneumococcal.
    - Tetanus, Diphtheria, Pertussis.
    - Varicella.
- Latent tuberculosis infection screening for adults ages 18 years and older that are at increased risk.

- Lung cancer screening, once per year, with low-dose computed tomography for adults ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years, but not for adults who have not smoked for 15 years or have developed a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.
- Obesity screening and counseling for all adults.
- Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk.
- Skin cancer behavioral counseling about minimizing exposure to ultraviolet radiation to reduce risk for skin cancer for young adults, up to 24 years, who have fair skin.
- Syphilis screening for adults at higher risk.
- Tobacco use screening for all adults and cessation interventions, including *FDA*-approved pharmacotherapy for cessation to nonpregnant adults who use tobacco.

Preventive health care services for women

Benefits under this section include the following when required by federal law:

- Asymptomatic bacteriuria screening with urine culture for pregnant women at 12 to 16 weeks gestation or at the first prenatal visit, if later.
- Breast cancer chemoprevention counseling for women at higher risk.
- Breast cancer genetic test counseling (BRCA) for women at higher risk for breast cancer.
- Breast cancer mammography screenings annually for women over 40.
- Breastfeeding comprehensive support and counseling from trained providers, and access to breastfeeding supplies, for pregnant and nursing women.
- Cervical cancer screening for sexually active women ages 21 to 65 years.
- Chlamydia infection screening for all sexually active non-pregnant young women aged 24 and younger, for all pregnant women aged 24 and younger, and for all older women who are at increased risk.
- Contraception - *U.S. Food and Drug Administration* approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity (not including over-the-counter or prescription drugs, or pharmaceutical products).
- Domestic and interpersonal violence screening and counseling for all women.
- Folic Acid supplement use counseling for women who may become pregnant.
- Gestational diabetes mellitus screening in asymptomatic pregnant women after 24 weeks of gestation.
- Gonorrhea screening for all women at higher risk.
- Hepatitis B screening for pregnant women at their first prenatal visit.
- HIV screening and counseling for sexually active women.
- Human Papillomavirus (HPV) DNA test every 3 years for women with normal cytology results who are 30 or older.
- Osteoporosis screening for women over age 60 depending on risk factors.

- Osteoporosis screening with bone measurement testing to prevent osteoporotic fractures in women 65 years and older and postmenopausal women younger than 65 who are at increased risk of osteoporosis.
- Preeclampsia screening with blood pressure measurements for pregnant women throughout Pregnancy.
- Rh (D) blood typing and antibody testing for all pregnant women during their first visit for Pregnancy-related care and repeated Rh (D) antibody testing for all un-sensitized Rh (D)-negative women at 24-28 weeks gestation, unless the biological father is known to be Rh (D)-negative.
- Sexually Transmitted Infections counseling for sexually active women.
- Syphilis screening for all pregnant women or other women at increased risk.
- Tobacco use screening and interventions for all women, and expanded counseling, including behavioral interventions for cessation to pregnant tobacco users.
- Well-woman visits.

Preventive health care services for children

Benefits under this section include the following when required by federal law:

- Alcohol misuse screening and intervention for adolescents.
- Anticipatory guidance: annually for children 3 years and older; more often if under 3.
- Autism screening for children at 18 and 24 months.
- Behavioral assessments for children as provided for in the comprehensive guidelines supported by *HRSA*.
- Blood pressure screening for children as provided for in the comprehensive guidelines supported by *HRSA*.
- Cervical dysplasia screening starting at age 21 years.
- Congenital hypothyroidism screening for newborns.
- Critical congenital heart defect screening for newborns.
- Dental cavities prevention for infants and children up to age 5 years where primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption.
- Depression screening for adolescents.
- Developmental screening for children under age 3.
- Developmental surveillance periodically for newborns to age 15 months and annually age 2 to 21.
- Dyslipidemia screening for children as provided for in the comprehensive guidelines supported by *HRSA*.
- Fluoride chemoprevention supplements use counseling for children without fluoride in their water source.
- Gonorrhea preventive medication for the eyes of all newborns.
- Hearing screening for all newborns.
- Height, weight and body mass index measurements for children as provided for in the comprehensive guidelines supported by *HRSA*.

- Hematocrit or hemoglobin screening for children.
- Hemoglobinopathies or sickle cell screening for newborns.
- Hepatitis B screening for non-pregnant adolescents at high risk for infection.
- HIV screening for adolescents at higher risk.
- Hypothyroidism screening for newborns.
- Immunization vaccines for children from birth to age 18 - doses, recommended ages, and recommended populations vary:
    - Diphtheria, Tetanus, Pertussis.
    - Haemophilus influenzae type b.
    - Hepatitis A.
    - Hepatitis B.
    - Human papillomavirus (HPV).
    - Inactivated poliovirus.
    - Influenza (flu shot).
    - Measles, Mumps, Rubella.
    - Meningococcal.
    - Pneumococcal.
    - Rotavirus.
    - Varicella.
- Intimate partner violence screening for women of childbearing age.
- Iron supplement use counseling for children ages 6 to 12 months at risk for anemia.
- Lead screening for children at risk of exposure.
- Medical history for all children throughout development as provided for in the comprehensive guidelines supported by *HRSA*.
- Obesity screening and counseling.
- Oral Health risk assessment for young children Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years.
- Phenylketonuria (PKU) screening for this genetic disorder in newborns.
- Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk.
- Skin cancer behavioral counseling about minimizing exposure to ultraviolet radiation to reduce risk for skin cancer for children, adolescents, and young adults, ages 6 months to 24 years, who have fair skin.
- Tobacco use interventions for children and adolescents, including education or brief counseling, to prevent initiation of tobacco use.
- Tuberculin testing for children at higher risk of tuberculosis as provided for in the comprehensive guidelines supported by *HRSA*.
- Vision screening for all children as provided for in the comprehensive guidelines supported by *HRSA*.

Illinois mandated preventive health care services

As required under Illinois law, Benefits under this section include:

- Contraceptive services:
  - All contraceptive drugs, devices, and other products approved by the *FDA*. Including all *FDA*-approved methods of over-the-counter drugs, devices, and products, excluding male condoms unless a female Covered Person obtains a prescription. Note that contraceptive medications which you obtain from a pharmacy are covered under *Section 11: Outpatient Prescription Drugs*.
  - Voluntary male sterilization is covered without cost share.
  - Contraceptive services, patient education, and counseling on contraception.
  - Follow-up services related to contraceptive drugs, devices, products, and procedures.
- Screening by Low-dose Mammography which includes, but is not limited to:
  - A baseline mammogram for Covered Persons who are 35 - 39 years of age.
  - An annual mammogram for Covered Persons who are 40 years of age and over.
  - A mammogram at the age and intervals considered to be Medically Necessary by the Covered Person's Physician for Covered Person's under 40 years of age and having a family history of breast cancer, prior personal history of breast cancer, positive genetic testing, or other risk factors.
  - A comprehensive ultrasound screening and magnetic resonance imaging MRI of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue or when Medically Necessary as determined by a Physician licensed to practice medicine in all of its branches, advanced practice registered nurse, or Physician assistant.
  - A screening MRI when Medically Necessary, as determined by a Physician licensed to practice medicine in all of its branches.
- Genetic Testing of the BRCA1 and BRCA2 genes to detect an increased risk for breast and/or ovarian cancer in accordance with the *USPSTF*.
- An annual cervical smear or Pap smear test.
- Surveillance tests for ovarian cancer for Covered Persons who are at risk for ovarian cancer.

  "At risk for ovarian cancer" means:
  - Having a family history:
    - With one or more first-degree relatives with ovarian cancer.
    - Of clusters of relatives with breast cancer.
    - Of nonpolyposis colorectal cancer.
  - Testing positive for BRCA1 or BRCA2 mutations.
- An annual prostate cancer screening including a digital rectal exam and a prostate specific antigen test and associated laboratory work upon the recommendation of a Physician for any of the following:
  - Asymptomatic Covered Persons age 50 and over.
  - African-American Covered Persons age 40 and over.
  - Covered Persons age 40 and over with a family history of or genetic predisposition to prostate cancer.

Benefits are available without cost share.

- A1c testing for prediabetes, type 1 diabetes, and type 2 diabetes in accordance with prediabetes and diabetes risk factors identified by the *United States Centers for Disease Control and Prevention*.

Benefits for screenings that do not meet the criteria above are described under the applicable Covered Health Care Services category in this *Certificate*.

29. Prosthetic Devices

External prosthetic devices that replace a limb or a body part, limited to:

- Artificial arms, legs, feet and hands.
- Artificial face, eyes, ears and nose.
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998.* Benefits include mastectomy bras. Benefits for lymphedema stockings for the arm are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies.*

Benefits are provided only for external prosthetic devices and do not include any device that is fully implanted into the body. Internal prosthetics are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Service categories in this *Certificate.*

If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. If you purchase a prosthetic device that exceeds these minimum specifications, we will pay only the amount that we would have paid for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

The prosthetic device must be ordered or provided by, or under the direction of a Physician.

Benefits are available for repairs and replacement, except as described in *Section 2: Exclusions and Limitations,* under *Devices, Appliances and Prosthetics.*

30. Reconstructive Procedures

Reconstructive procedures when the primary purpose of the procedure is either of the following:

- Treatment of a medical condition.
- Improvement or restoration of physiologic function.

Reconstructive procedures include surgery or other procedures which are related to an Injury, trauma, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance, but rather to restore the affected body part to its normal or functional state.

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures, except in the case of newborn children diagnosed with congenital defects or birth abnormalities. The fact that you may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Benefits are available for the care and treatment of cleft lip and cleft palate for children under age 19. Benefits include oral and facial surgery; prosthetic treatment; orthodontic, prosthodontic, and otolaryngology treatment and management. Benefits do not include cosmetic surgery performed to reshape normal structures of the lip, jaw, palate, or other facial structures to improve appearance.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry.

Benefits include breast implant removal of an existing breast implant when the removal is Medically Necessary for a Sickness or Injury following a mastectomy. Benefits do not include the removal of breast implants that were implanted solely for cosmetic reasons.

Benefits include Medically Necessary breast reduction surgery.

Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Care Service. You can call us at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

31. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

Short-term outpatient rehabilitation services limited to:

- Physical therapy.
- Preventive Physical Therapy for multiple sclerosis.
- Occupational therapy.
- Manipulative Treatment.
- Speech therapy.
- Pulmonary rehabilitation therapy.
- Cardiac rehabilitation therapy.
- Post-cochlear implant aural therapy.
- Cognitive rehabilitation therapy.

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Rehabilitative services provided in your home by a Home Health Agency are provided as described under Home Health Care. Rehabilitative services provided in your home other than by a Home Health Agency are provided as described under this section.

Benefits can be denied or shortened when either of the following applies:

- You are not progressing in goal-directed rehabilitation services.
- Rehabilitation goals have previously been met.

Benefits are not available for maintenance/preventive treatment.

For outpatient rehabilitative services for speech therapy we will pay Benefits for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, or Congenital Anomaly.

32. Scopic Procedures - Outpatient Diagnostic and Therapeutic

Diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital, Alternate Facility, or in a Physician's office.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include:

- Colonoscopy.

- Sigmoidoscopy.
- Diagnostic endoscopy.

Please note that Benefits do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for all other Physician services are described under *Physician Fees for Surgical and Medical Services*.)
- Colorectal cancer screenings in accordance with the published *American Cancer Society* guidelines on colorectal cancer screening or other existing colorectal cancer screening guidelines issued by the nationally recognized professional medical societies or federal government agencies, including the *National Cancer Institute,* the *Centers for Disease Control and Prevention,* and the *American College of Gastroenterology*. Colorectal cancer screenings that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force* are described under *Preventive Care Services*.
- Follow-up colonoscopy exam based on an initial screening where the colonoscopy was determined to be Medically Necessary by a Physician, an advanced practice registered nurse, or a physician assistant. Benefits are available without cost share.

Benefits that apply to certain preventive screenings are described under *Preventive Care Services*.

Please refer to your *Schedule of Benefits* under *Physician's Office Services - Sickness and Injury* for how cost shares (Co-payment and/or deductible as applicable) apply, when services are provided in a Physician's office.

33. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Services and supplies provided during an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Please note that Benefits are available only if both of the following are true:

- If the first confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost effective option to an Inpatient Stay in a Hospital.
- You will receive Skilled Care services that are not primarily Custodial Care.

To determine the availability of Benefits, both the skilled nature of the service and the need for Physician-directed medical management will be reviewed.

Benefits can be denied or shortened when either of the following applies:

- You are not progressing in goal-directed rehabilitation services.
- Discharge rehabilitation goals have previously been met.

34. Surgery - Outpatient

Surgery and related services received on an outpatient basis at a Hospital, Alternate Facility, or in a Physician's office.

Benefits include certain scopic procedures. Examples of surgical scopic procedures include:

- Arthroscopy.
- Laparoscopy.
- Bronchoscopy.
- Hysteroscopy.

Examples of surgical procedures performed in a Physician's office are mole removal, ear wax removal, and cast application.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Please refer to your *Schedule of Benefits* under *Physician's Office Services - Sickness and Injury* for how cost shares (Co-payment and/or deductible as applicable) apply, when services are provided in a Physician's office.

35. Temporomandibular Joint (TMJ) and Craniomandibular Disorder (CMD) Services

Services for the evaluation and treatment of TMJ, CMD and associated muscles.

Diagnosis: Exam, radiographs and applicable imaging studies and consultation.

Non-surgical treatment including:

- Clinical exams.
- Oral appliances (orthotic splints).
- Arthrocentesis.
- Trigger-point injections.

Benefits are provided for surgical treatment if the following criteria are met:

- There is radiographic evidence of joint abnormality.
- Non-surgical treatment has not resolved the symptoms.
- Pain or dysfunction is moderate or severe.

Benefits for surgical services include:

- Arthrocentesis.
- Arthroscopy.
- Arthroplasty.
- Arthrotomy.
- Open or closed reduction of dislocations.

Benefits for surgical services also include *FDA*-approved TMJ prosthetic replacements when all other treatment has failed.

36. Therapeutic Treatments - Outpatient

Therapeutic treatments received on an outpatient basis at a Hospital, Alternate Facility, or in a Physician's office, including:

- Dialysis (both hemodialysis and peritoneal dialysis).
- Intravenous chemotherapy or other intravenous infusion therapy.
- Radiation oncology, including proton beam therapy for the treatment of cancer.

Covered Health Care Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered health care professionals when both of the following are true:

- Education is required for a disease in which patient self-management is a part of treatment.
- There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

Benefits include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.

Please refer to your *Schedule of Benefits* under *Physician's Office Services - Sickness and Injury* for how cost shares (Co-payment and/or deductible as applicable) apply, when services are provided in a Physician's office.

37. Transplantation Services

Organ and tissue transplants, including CAR-T cell therapy for malignancies, when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Care Service, and is not an Experimental or Investigational Service.

Examples of transplants for which Benefits are available include:

- Bone marrow, including CAR-T cell therapy for malignancies.
- Heart.
- Heart/lung.
- Lung.
- Kidney.
- Kidney/pancreas.
- Liver.
- Liver/small intestine.
- Pancreas.
- Small intestine.
- Cornea.

Donor costs related to transplantation are Covered Health Care Services and are payable through the organ recipient's coverage under the Policy, limited to donor:

- Identification.

- Evaluation.
- Organ removal.
- Direct follow-up care.

You can call us at the telephone number on your ID card for information about our specific guidelines regarding Benefits for transplant services.

38. Urgent Care Center Services

Covered Health Care Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services - Sickness and Injury*.

39. Urinary Catheters

Benefits for external, indwelling, and intermittent urinary catheters for incontinence or retention.

Benefits include related urologic supplies for indwelling catheters limited to:

- Urinary drainage bag and insertion tray (kit).
- Anchoring device.
- Irrigation tubing set.

40. Virtual Care Services

Virtual care for Covered Health Care Services that includes the diagnosis and treatment of less serious conditions. Virtual care provides communication of medical information in real-time between the patient and a distant Physician or health specialist, outside of a medical facility (for example, from home or from work).

Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting us at www.myuhc.com or the telephone number on your ID card.

Benefits are available for urgent, on-demand health care delivered through live audio with video or audio only technology for treatment of acute but non-emergency needs.

Please Note: Not all conditions can be treated through virtual care. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is needed.

Benefits do not include email, or fax and standard telephone calls, or for services that occur within medical facilities (*CMS* defined originating facilities).

41. Vision Exams

Routine vision exams received from a health care provider in the provider's office or outpatient facility. Routine vision exams include refraction to find vision impairment.

Benefits for eye exams required for the diagnosis and treatment of a Sickness or Injury are provided under *Physician's Office Services - Sickness and Injury*.

42. Wigs

Wigs and other scalp hair prostheses regardless of the reason for hair loss.

Additional Benefits Required By Illinois Law

43. Dental Services - Anesthesia and Facility

Services for general anesthesia and associated Hospital or Alternate Facility charges when the dentist and Physician determine that the services are necessary for the safe and effective treatment of a dental condition. Services are limited to a Covered Person who:

- Is six years of age and under;
- Has one or more medical conditions that require hospitalization or general anesthesia for dental care; or
- Is a person with a disability.

Services for general anesthesia provided by a dentist who has obtained a permit for the administration of anesthetics under the *Illinois Dental Practice Act*, in conjunction with dental care that is provided to a Covered Person in a dental office, oral surgeon's office, Hospital or ambulatory surgical treatment center will be provided if the Covered Person:

- Is under age 26; and
- Has been diagnosed with an Autism Spectrum Disorder or a developmental disability.

Note: A Covered Person must make two visits to the dental care provider before accessing this coverage.

44. Examination and Treatment for Sexual Assault

Benefits include, at no cost share, the exam and testing of a victim of a criminal sexual assault or abuse to determine whether sexual contact occurred, and to establish the presence or absence of sexually transmitted disease or infection. Benefits also include exam and treatment of injuries and trauma sustained by the victim.

45. Human Breast Milk

Benefits include pasteurized donated human breast milk, which may include human milk fortifiers if indicated by a prescribing licensed Physician, for:

- Covered Persons under the age of six months, when all of the following conditions are met.
  - A licensed Physician prescribes the milk, and the milk is determined to be Medically Necessary.
  - The milk is obtained from a human milk bank that meets quality guidelines established by the *Human Milk Banking Association of North America* or is licensed by the *Department of Public Health*.
  - The infant's mother is medically or physically unable to produce maternal breast milk or produce sufficient quantities to meet the infant's needs or the maternal breast milk is contraindicated.
  - One or more of the following applies:
    - The infant's birth weight is below 1,500 grams.
    - The infant has a congenital or acquired condition that places the infant at a high risk for development of necrotizing enterocolitis.
    - The infant has infant hypoglycemia.
    - The infant has congenital heart disease.
    - The infant has had or will have an organ transplant.
    - The infant has sepsis.

        - The infant has any other serious congenital or acquired condition for which the use of donated human breast milk is Medically Necessary and supports the treatment and recovery of the infant.

- Covered Persons six months through 12 months of age, when all of the following conditions are met.
    - A licensed Physician prescribes the milk, and the milk is determined to be Medically Necessary.
    - The milk is obtained from a human milk bank that meets quality guidelines established by the *Human Milk Banking Association of North America* or is licensed by the *Department of Public Health*.
    - The child's mother is medically or physically unable to produce maternal breast milk or produce sufficient quantities to meet the child's needs or the maternal breast milk is contraindicated.
    - One or more of the following applies:
        - The child has spinal muscular atrophy.
        - The child's birth weight was below 1,500 grams and he or she has long-term feeding or gastrointestinal complications related to prematurity.
        - The child has had or will have an organ transplant.
        - The child has a congenital or acquired condition for which the use of donated human breast milk is Medically Necessary and supports the treatment and recovery of the child.

46. Jaw Care Services

Benefits include services for care and treatment due to major injury to the jaw as a result of an accident or disease. Services include:

- Oral and facial surgery, including reconstructive services and procedures necessary to improve, restore, or maintain vital functions.
- Dental implants, crowns, or bridges.
- Prosthetic treatment such as obturators, speech appliances, and feeding appliances.
- Orthodontic treatment and management.
- Prosthodontic treatment and management.
- Otolaryngology treatment and management.

47. Neuromuscular, Neurological, or Cognitive Impairment Treatment

Benefits include services for therapy, diagnostic testing, and equipment necessary to increase the quality of life for children who have been clinically or genetically diagnosed with any disease, syndrome or disorder that includes low tone neuromuscular impairment, neurological impairment, or cognitive impairment.

48. Pediatric Palliative Care

Pediatric palliative care for any qualified child with a serious Sickness. Benefits include care provided by a trained interdisciplinary team that allows a child to receive community-based pediatric palliative care while continuing to pursue curative treatment and disease-directed therapies for the qualifying Sickness.

Covered Health Care Services for hospice care provided by a licensed hospice agency are described under *Hospice Care*.

49. Port-Wine Stain Treatment

Benefits include treatment to eliminate or provide maximum feasible treatment of nevus flammeus, also known as port-wine stains, including but not limited to, port-wine stains caused by Sturge-Weber syndrome.

For purposes of this Benefit, treatment or maximum feasible treatment includes early intervention treatment, including topical, intralesional, or systemic medical therapy and surgery, and laser treatments approved by the *U.S. Food and Drug Administration* for Covered Persons aged 18 years and younger. These are intended to prevent functional impairment related to vision function, oral function, inflammation, bleeding, infection, and other medical complications associated with port-wine stains.

Benefits include Medically Necessary services for Covered Persons over 18 years of age. Benefits do not include treatment solely for cosmetic purposes.

50. Telehealth Services

Benefits are provided for services delivered via Telehealth by health care professionals, including licensed dietitians, nutritionists and certified diabetes educators who counsel senior diabetic Covered Persons in the home. Benefits are also provided for Remote Physiologic Monitoring and tele-psychiatry care. Benefits for these services are provided to the same extent and will not exceed the applicable cost share as an in-person service under any applicable Benefit category in this section.

An in-person consultation is not required prior to receiving Telehealth Services. If you prefer an in-person consultation instead of Telehealth Services, Benefits are available under the applicable Benefit category in this section.

Section 2: Exclusions and Limitations

How Do We Use Headings in this Section?

To help you find exclusions, we use headings (for example *A. Alternative Treatments* below). The headings group services, treatments, items, or supplies that fall into a similar category. Exclusions appear under the headings. A heading does not create, define, change, limit or expand an exclusion. All exclusions in this section apply to you.

We Do Not Pay Benefits for Exclusions

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Care Services, except as may be specifically provided for in *Section 1: Covered Health Care Services* or through a Rider to the Policy.

Where Are Benefit Limitations Shown?

When Benefits are limited within any of the Covered Health Care Service categories described in *Section 1: Covered Health Care Services*, those limits are stated in the corresponding Covered Health Care Service category in the *Schedule of Benefits*. Limits may also apply to some Covered Health Care Services that fall under more than one Covered Health Care Service category. When this occurs, those limits are also stated in the *Schedule of Benefits* table. Please review all limits carefully, as we will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

A. Alternative Treatments

1. Acupressure and acupuncture.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Wilderness, adventure, camping, outdoor, or other similar programs.
7. Art therapy, music therapy, dance therapy, animal-assisted therapy, and other forms of alternative treatment as defined by the *National Center for Complementary and Integrative Health (NCCIH)* of the *National Institutes of Health*. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care, or Treatment for Autism Spectrum Disorders for which Benefits are provided as described in *Section 1: Covered Health Care Services*.

B. Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all related expenses, including hospitalizations and anesthesia).

This exclusion does not apply to accident-related dental services or dental anesthesia and associated hospital or alternate facility charges for which Benefits are provided as described under *Section 1: Covered Health Care Services.*

This exclusion does not apply to dental care (oral exam, X-rays, extractions and non-surgical elimination of oral bacterial infections - except infections which result from accidental Injury, or infection which results from accidental, involuntary or unintentional ingestion of a contaminated substance) required for the direct treatment of a medical condition for which Benefits are available under the Policy, limited to:

- Transplant preparation.
- Prior to the 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 tooth decay or cavities resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:

   - Removal, restoration and replacement of teeth.
   - Medical or surgical treatments of dental conditions.
   - Services to improve dental clinical outcomes.

   This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement or the *Health Resources and Services Administration (HRSA) requirement.* This exclusion also does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Care Services.*

3. 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: Covered Health Care Services.*

4. Dental braces (orthodontics). This exclusion does not apply to orthodontics associated with cleft lip or cleft palate for which Benefits are provided as described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.

5. Treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a Congenital Anomaly.

C. Devices, Appliances and Prosthetics

1. Devices used as safety items or to help performance in sports-related activities.

2. 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. This exclusion does not apply to cranial molding helmets and cranial banding that meet clinical criteria. This exclusion does not apply to braces for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services.*

3. The following items are excluded, even if prescribed by a Physician:

   - Blood pressure cuff/monitor.
   - Enuresis alarm.

- Non-wearable external defibrillator.
- Trusses.
- Ultrasonic nebulizers.

4. Devices and computers to help in communication and speech except for dedicated speech generating devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services*.
5. Oral appliances for snoring.
6. Repair or replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.
7. Diagnostic or monitoring equipment purchased for home use, unless otherwise described as a Covered Health Care Service.
8. Powered and non-powered exoskeleton devices.
9. Over-the-counter continuous glucose monitors.

D. Drugs

Please note that these exclusions apply only to those services identified in *Section 1: Covered Health Care Services*. Benefits for outpatient prescription drugs and related exclusions appear in *Section 11: Outpatient Prescription Drugs* and the *Outpatient Prescription Drug Schedule of Benefits.*

1. Prescription drug products for outpatient use that are filled by a prescription order or refill, except prescription inhalants or inhalers, outpatient contraceptive prescription drugs and diabetic prescription drugs for which Benefits are provided as described under *Section 11: Outpatient Prescription Drugs*. This exclusion does not apply to prescription drugs for Infertility as described under *Infertility Services* in *Section 1: Covered Health Care Services.*
2. Self-administered or self-infused medications, except in the case of medications necessary to treat diabetes as described under *Section 11: Outpatient Prescription Drugs*. This exclusion does not apply to medications which, due to their traits, must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to certain hemophilia treatment centers that are contracted with a specific hemophilia treatment center fee schedule that allows medications used to treat bleeding disorders to be dispensed directly to Covered Persons for self-administration.
3. 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 used while in the Physician's office.
4. Over-the-counter drugs and treatments. This exclusion does not apply to over-the-counter *FDA*-approved contraceptive drugs, devices, and products as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration* and as required by Illinois law when prescribed by a Network provider for which Benefits are available, without cost sharing, as described under *Preventive Care Services* in *Section 1: Covered Health Care Services.*
5. Growth hormone therapy.
6. Certain New Pharmaceutical Products and/or new dosage forms until the date as determined by us or our designee, but no later than December 31st of the following calendar year.

   This exclusion does not apply if you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening Sickness or condition, under such circumstances, Benefits may be available for the New Pharmaceutical Product to the extent provided in *Section 1: Covered Health Care Services.*

7. 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 or prescription drug product as described in *Section 11: Outpatient Prescription Drugs*. Such determinations may be made up to six times during a calendar year.
8. 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 or prescription drug product as described in *Section 11: Outpatient Prescription Drugs*. Such determinations may be made up to six times during a calendar year.
9. A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product or prescription drug product as described in *Section 11: Outpatient Prescription Drugs*. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year.
10. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives to another Pharmaceutical Product or prescription drug product as described in *Section 11: Outpatient Prescription Drugs* available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year.
11. Certain Pharmaceutical Products that have not been prescribed by a Specialist.
12. Compounded drugs that contain certain bulk chemicals. Compounded drugs that are available as a similar commercially available Pharmaceutical Product.

E. Experimental or Investigational Services

Experimental or Investigational Services and all services related to Experimental or Investigational Services are excluded. The fact that an Experimental or Investigational 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 an Experimental or Investigational Service in the treatment of that particular condition.

This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Care Services.*

F. Foot Care

1. Routine foot care. Examples include:
   - Cutting or removal of corns and calluses.
   - Nail trimming, nail cutting, or nail debridement.
   - Hygienic and preventive maintenance foot care including cleaning and soaking the feet and applying skin creams in order to maintain skin tone.

   This exclusion does not apply to preventive foot care due to conditions associated with metabolic, neurologic, or peripheral vascular disease.
2. Treatment of flat feet.
3. Treatment of subluxation of the foot.
4. Shoes.

5. Shoe orthotics.
6. Shoe inserts.
7. Arch supports.

G. Medical Supplies and Equipment

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
   - Compression stockings.
   - Ace bandages.
   - Gauze and dressings.

   This exclusion does not apply to:
   - Disposable supplies necessary for the effective use of DME or prosthetic devices for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies* and *Prosthetic Devices* in *Section 1: Covered Health Care Services.* This exception does not apply to supplies for the administration of medical food products.
   - Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Care Services*.
   - Ostomy supplies for which Benefits are provided as described under *Ostomy Supplies* in *Section 1: Covered Health Care Services.*
   - Urinary catheters and related urologic supplies for which Benefits are provided as described under *Urinary Catheters* in *Section 1: Covered Health Care Services*.
   - Compression sleeves when Medically Necessary to prevent or mitigate lymphedema.
2. Tubings and masks except when used with DME as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services.*
3. Prescribed or non-prescribed publicly available devices, software applications and/or monitors that can be used for non-medical purposes.
4. Repair or replacement of DME or orthotics due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

H. Nutrition

1. Individual and group nutritional counseling, including non-specific disease nutritional education such as general good eating habits, calorie control or dietary preferences. This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement. This exclusion also does not apply to medical or behavioral/mental health related nutritional education services that are provided as part of treatment for a disease 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 a part of treatment.
   - There is a lack of knowledge regarding the disease which requires the help of a trained health professional.
2. Food of any kind, infant formula, standard milk-based formula, and donor breast milk. This exclusion does not apply to specialized enteral formula and donated human breast milk for which Benefits are provided as described under *Enteral Nutrition* and *Human Breast Milk* in *Section 1: Covered Health Care Services*.

3. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements and electrolytes.

I. Personal Care, Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
    - Air conditioners, air purifiers and filters and 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 as described under *Preventive Care Services* in *Section 1: Covered Health Care Services.*
    - Car seats.
    - Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners.
    - Exercise equipment.
    - Home modifications such as elevators, handrails and ramps.
    - Hot and cold compresses.
    - 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.

J. Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 9: Defined Terms*. 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. This exclusion does not apply to liposuction for which Benefits are provided as described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services.*
   - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
   - Treatment for spider veins.
   - Sclerotherapy treatment of veins.
   - Hair removal or replacement by any means, except for hair removal as part of genital reconstruction prescribed by a Physician for the treatment of gender dysphoria.
2. 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 first breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, or flexibility.
5. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.

K. Procedures and Treatments

1. Removal of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).
3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
4. Rehabilitation services and Manipulative Treatment to improve general physical conditions that are provided to reduce potential risk factors, where improvement is not expected, including routine, long-term or maintenance/preventive treatment.
5. Rehabilitation services for speech therapy except as required for treatment of a speech impairment or speech dysfunction that results from Injury, stroke, cancer, or Congenital Anomaly.
6. Habilitative services for maintenance/preventive treatment.
7. Physiological treatments and procedures that result in the same therapeutic effects when performed on the same body region during the same visit or office encounter.
8. Biofeedback.

9. 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; and dental restorations.

10. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery when there is a facial skeletal abnormality and associated functional medical impairment.

11. Non-surgical treatment of obesity.

12. Stand-alone multi-disciplinary tobacco cessation programs. These are programs that usually include health care providers specializing in tobacco cessation and may include a psychologist, social worker or other licensed or certified professionals. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings. This exclusion does not apply to tobacco cessation services and screening for which Benefits are provided as described under *Preventive Care Services* in *Section 1: Covered Health Care Services*.

13. Breast reduction surgery that is determined to be a Cosmetic Procedure. This exclusion does not apply to breast reduction surgery which is Medically Necessary, requested to treat a physiologic functional impairment or coverage required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services*. This exclusion does not apply to breast reduction surgery for treatment of Gender Dysphoria.

14. Helicobacter pylori *(H. pylori)* serologic testing.

15. Intracellular micronutrient testing.

16. Cellular and Gene Therapy services not received from a Designated Provider.

L. Providers

1. 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.

2. Services performed by a provider with your same legal address.

3. Services provided at a Freestanding Facility or diagnostic Hospital-based Facility without an order written by a Physician or other provider. Services which are self-directed to a Freestanding Facility or diagnostic Hospital-based Facility. Services ordered by a Physician or other provider who is an employee or representative of a Freestanding Facility or diagnostic Hospital-based Facility, when that Physician or other provider:

   - Has not been involved in your medical care prior to ordering the service, or
   - Is not involved in your medical care after the service is received.

   This exclusion does not apply to mammography.

M. Reproduction

1. The following Infertility treatment-related services:

   - Long-term storage (greater than one year) of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue.
   - Donor services, except those described under *Infertility Services* in *Section 1: Covered Health Care Services.*

2. The following services related to a Gestational Carrier or Surrogate:

- All costs related to reproductive techniques including:
  - Assisted Reproductive Technology (ART).
  - Artificial insemination.
  - Intrauterine insemination.
  - Obtaining and transferring embryo(s).
  - Preimplantation Genetic Testing (PGT) and related services.

  The exclusion for costs related to reproductive techniques does not apply when the Gestational Carrier or Surrogate is for a Covered Person for whom Benefits are provided as described under *Infertility Services* and *Preimplantation Genetic Testing (PGT) and Related Services* in *Section 1: Covered Health Care Services*. This exclusion also does not apply when the Covered Person is directly participating in the Infertility services provided by or to a Gestational Carrier or Surrogate.
- Health care services including:
  - Inpatient or outpatient prenatal care and/or preventive care.
  - Screenings and/or diagnostic testing.
  - Delivery and post-natal care.

  The exclusion for the health care services listed above does not apply when the Gestational Carrier or Surrogate is a Covered Person.
- All fees including:
  - Screening, hiring and compensation of a Gestational Carrier or Surrogate including surrogacy agency fees.
  - Surrogate insurance premiums.
  - Travel or transportation fees.

3. Costs of donor eggs and donor sperm.
4. The reversal of voluntary sterilization.
5. Elective fertility preservation.
6. In vitro fertilization that is not an Assisted Reproductive Technology for the treatment of Infertility. This exclusion does not apply to in vitro fertilization for which Benefits are provided as described under *Preimplantation Genetic Testing (PGT) and Related Services* in *Section 1: Covered Health Care Services.*

N. Services Provided under another Plan

1. Health care services for when other coverage is required by federal, state or local law to be bought or provided through other arrangements. Examples include coverage required by workers' compensation, or similar legislation.

   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.
2. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.

3. Health care services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
4. Health care services during active military duty.

O. Transplants

1. Health care services for organ and tissue transplants, except those described under *Transplantation Services* in *Section 1: Covered Health Care Services*.
2. Health care 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.)
3. Health care services for transplants involving animal organs.
4. Transplant services not received from a Designated Provider. This exclusion does not apply to cornea transplants.

P. Travel

1. Health care services provided in a foreign country, unless required as Emergency Health Care Services.
2. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Care Services received from a Designated Provider or other Network provider may be paid back. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in *Section 1: Covered Health Care Services.*

Q. Types of Care, Supportive Services, and Housing

1. Multi-disciplinary pain management programs provided on an inpatient basis for sharp, sudden pain or for worsened long term pain.
2. Custodial Care or maintenance care.
3. Domiciliary care.
4. Private Duty Nursing.
5. Respite care. This exclusion does not apply to respite care for which Benefits are provided as described under *Hospice Care* in *Section 1: Covered Health Care Services*.
6. Rest cures.
7. Services of personal care aides.
8. Independent living services.
9. Assisted living services.
10. Educational counseling, testing, and support services including tutoring, mentoring, tuition, and school-based services for children and adolescents required to be provided by or paid for by the school under the *Individuals with Disabilities Education Act*.
11. Vocational counseling, testing, and support services including job training, placement services, and work hardening programs (programs designed to return a person to work or to prepare a person for specific work).
12. Transitional Living services (including recovery residences).

R. Vision and Hearing

1. Cost and fitting charge for eyeglasses and contact lenses.
2. Implantable lenses used only to fix a refractive error (such as *Intacs* corneal implants).
3. Eye exercise or vision therapy.
4. 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.
5. Bone anchored hearing aids except when either of the following applies:
   - You have craniofacial anomalies whose abnormal or absent ear canals prevent the use of a wearable hearing aid.
   - You have hearing loss of sufficient severity that it would not be remedied enough 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 you are enrolled under the Policy.

   Repairs and/or replacement for a bone anchored hearing aid when you meet the above coverage criteria, other than for malfunctions.

S. All Other Exclusions

1. Health care services and supplies that do not meet the definition of a Covered Health Care Service. Covered Health Care Services are those health services, including services, supplies, or Pharmaceutical Products, which are determined to be all of the following:
   - Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
   - Medically Necessary.
   - Described as a Covered Health Care Service in this *Certificate* under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*.
   - Not otherwise excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.
2. Physical, psychiatric or psychological exams, testing, all forms of vaccinations and immunizations or treatments that are otherwise covered under the Policy when:
   - Required only for school, sports or camp, travel, career or employment, insurance, marriage, Civil Union or adoption.
   - Related to judicial or administrative proceedings or orders. This exclusion does not apply to services that are determined to be Medically Necessary.
   - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Care Services.*
   - Required to get or maintain a license of any type.
3. Health care 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 if you are a civilian injured or otherwise affected by war, any act of war, or terrorism in non-war zones.
4. Health care services received after the date your coverage under the Policy ends. This applies to all health care services, even if the health care service is required to treat a medical condition that started before the date your coverage under the Policy ended.

5. Health care services when you have no legal responsibility to pay, or when a charge would not ordinarily be made in the absence of coverage under the Policy.
6. Charges in excess of the Allowed Amount, when applicable, or in excess of any specified limitation.
7. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
8. Autopsy.
9. Foreign language and sign language interpretation services offered by or required to be provided by a Network or out-of-Network provider.
10. Health care services related to a non-Covered Health Care Service: When a service is not a Covered Health Care Service, all services related to that non-Covered Health Care Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Care Services if the service treats complications that arise from the non-Covered Health Care 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 bacterial infections - except infections which result from accidental Injury, or infection which results from accidental, involuntary or unintentional ingestion of a contaminated substance, following a Cosmetic Procedure, that require hospitalization.