UnitedHealthcare of Illinois, Inc.
200 E. Randolph Street / Suite 5300 / Chicago, IL 60601

Benefit Summary

UHC Navigate HSA Bronze 5500
Illinois - Navigate
Navigate HSA - Plan AL2D

What is a benefit summary?

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

What are the benefits of the UnitedHealthcare Navigate® Plan with an HSA?

Get a plan with a Primary Care Provider (PCP) to help coordinate your care and get an HSA.

This is a health plan that requires you to select a PCP who can help guide you through the health care system so you can get the right care at the right time. Plus, you can open a health savings account (HSA). An HSA is a personal bank account to help you save and pay for your health care, and help you save on taxes.

> **Select your personal PCP from the plan network.** Each enrolled person must select a PCP. Your PCP must be in an area where you (the subscriber) lives. Your PCP will be your first point of contact when you need care.

> **You need to get online referrals from your PCP to see a network specialist.**

> **There's no coverage if you go out of network or if you see a network specialist without a referral.** You will be responsible for the entire cost of the service.

> **Preventive care is covered 100% in our network.**

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

Are you a member?

Easily manage your benefits online at **myuhc.com®** and on the go with the **UnitedHealthcare Health4Me™** mobile app.

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

Benefits At-A-Glance

What you may pay for network care

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

Co-insurance (Your cost for an office visit)	Individual Deductible (Your cost before the plan starts to pay)	Co-insurance (Your cost share after the deductible)
30%	$5,500	30%

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

UnitedHealthcare of Illinois, Inc.

Your Costs

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

Your cost if you use Network Benefits

Deductible - Combined Medical and Pharmacy

What is a deductible?

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

> All individual deductible amounts will count towards meeting the family deductible, but an individual will not have to pay more than the individual deductible amount.

Medical Deductible - Individual	$5,500 per year
Medical Deductible - Family	$11,000 per year
Dental - Pediatric Services Deductible - Individual	Included in your medical deductible.
Dental - Pediatric Services Deductible - Family	Included in your medical deductible.

Out-of-Pocket Limit - Combined Medical and Pharmacy

What is an out-of-pocket limit?

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

> Your co-pays, co-insurance and deductibles (including pharmacy) count towards meeting the out-of-pocket limit.

> All individual out-of-pocket limit amounts will count towards meeting the family out-of-pocket limit, but an individual will not have to pay more than the individual out-of-pocket limit amount.

Out-of-Pocket Limit - Individual	$6,550 per year
Out-of-Pocket Limit - Family	$13,100 per year

What is co-insurance?

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

What is a co-payment?

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

What is Prior Authorization?

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

Want more information?

Find additional definitions in the glossary at justplainclear.com.

Your Costs

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

Common Medical Event	Your cost if you use Network Benefits
Ambulance Services	
Emergency	30% co-insurance, after the medical deductible has been met.
Non-Emergency	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for Non-Emergency Ambulance.
Amino Acid-Based Elemental Formulas	
Diagnosis and Treatment	The amount you pay is based on where the covered health service is provided.
Amino acid-based formulas for the treatment of eosinopholic disorders and short bowel syndrome.	30% co-insurance, after the medical deductible has been met or as stated under the Outpatient Prescription Drug Rider. Prior Authorization is required for certain services.
Autism Spectrum Disorders	
	30% co-insurance, after the medical deductible has been met.
Clinical Trials (Including Cancer Clinical Trials)	
	The amount you pay is based on where the covered health service is provided. Prior Authorization is required, except for routine patient care costs associated with cancer clinical trials.
Congenital Heart Disease (CHD) Surgeries	
	30% co-insurance, after the medical deductible has been met (with a referral from your Primary Physician).
Customized Orthotic Devices	
	30% co-insurance, after the medical deductible has been met.

Your Costs

Common Medical Event	Your cost if you use Network Benefits
Dental - Pediatric Services (Benefits covered up to age 19)	
Benefits provided by the National Options PPO 20 Network (INO-MAC).	
Dental - Pediatric Preventive Services	
Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.	You pay nothing, after the medical deductible has been met.
Fluoride Treatments Limited to 2 times per 12 months.	You pay nothing, after the medical deductible has been met.
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	You pay nothing, after the medical deductible has been met.
Space Maintainers Benefit includes all adjustments within 6 months of installation.	You pay nothing, after the medical deductible has been met.
Dental - Pediatric Diagnostic Services	
Periodic Oral Evaluation (Check-up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	You pay nothing, after the medical deductible has been met.
Radiographs Limited to 2 series of films per 12 months for Bitewing and 1 time per 36 months for Complete/Panorex.	You pay nothing, after the medical deductible has been met.

Your Costs

Common Medical Event	Your cost if you use Network Benefits
Dental - Pediatric Basic Dental Services	
Endodontics (Root Canal Therapy)	20% co-insurance, after the medical deductible has been met.
General Services (Including Emergency treatment) Palliative Treatment: Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General Anesthesia: Covered when clinically necessary. Occlusal Guard: Limited to 1 guard every 12 months and only covered if prescribed to control habitual grinding.	20% co-insurance, after the medical deductible has been met.
Oral Surgery (Including Surgical Extractions)	20% co-insurance, after the medical deductible has been met.
Periodontics Periodontal Surgery: Limited to 1 quadrant or site per 36 months per surgical area. Scaling and Root Planing: Limited to 1 time per quadrant per 24 months. Periodontal Maintenance: Limited to 4 times per 12 months. In conjunction with dental prophylaxis, following active and adjunctive periodontal therapy within the prior 24 months, exclusive of gross debridement.	20% co-insurance, after the medical deductible has been met.
Restorations (Amalgam or Anterior Composite) Multiple restorations on one surface will be treated as one filling.	20% co-insurance, after the medical deductible has been met.
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	20% co-insurance, after the medical deductible has been met.

Your Costs

Common Medical Event	Your cost if you use Network Benefits
Dental - Pediatric Major Restorative Services	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months.	50% co-insurance, after the medical deductible has been met.
Dentures and other removable Prosthetics (Full denture/partial denture) Limited to 1 time per 60 months.	50% co-insurance, after the medical deductible has been met.
Fixed Partial Dentures (Bridges) Limited to 1 time per tooth per 60 months.	50% co-insurance, after the medical deductible has been met.
Implants Limited to 1 time per tooth per 60 months.	50% co-insurance, after the medical deductible has been met.
Dental - Pediatric Medically Necessary Orthodontics	
Benefits for comprehensive orthodontic treatment are approved by us and limited to children meeting or exceeding a score of 42 from the Modified Salzmann Index or meeting the criteria for medical necessity.	50% co-insurance, after the medical deductible has been met. Prior Authorization required for orthodontic treatment.
Dental Services - Accident or Injury Only	
	30% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Dental Services - Anesthesia and Facility	
	The amount you pay is based on where the covered health service is provided.
Diabetes Services	
Diabetes Self Management and Training/Diabetic Eye Examinations/ Foot Care:	The amount you pay is based on where the covered health service is provided.
Diabetes Self Management Items:	The amount you pay is based on where the covered health service is provided under Durable Medical Equipment or in the Prescription Drug Rider.
Durable Medical Equipment	
	30% co-insurance, after the medical deductible has been met.

Your Costs

Common Medical Event	Your cost if you use Network Benefits
Emergency Health Services - Outpatient	
	30% co-insurance, after the medical deductible has been met. Notification is required if confined in an Out-of-Network Hospital.
Examination and Treatment for Sexual Assault	
	The amount you pay is based on where the covered health service is provided. Any applicable deductible, Co-insurance and Co-payments will be waived.
Hearing Aids	
Limited to two hearing aids every 36 months.	30% co-insurance, after the medical deductible has been met.
Home Health Care	
	30% co-insurance, after the medical deductible has been met.
Hospice Care	
	30% co-insurance, after the medical deductible has been met.
Hospital - Inpatient Stay	
	30% co-insurance, after the medical deductible has been met (with a referral from your Primary Physician).
Infertility Services	
Benefits for Assisted Reproductive Technology (ART) are limited to four oocyte retrievals per lifetime; however, if a retrieval is followed by a live birth, two additional oocyte retrievals will be covered for a maximum of six oocyte retrievals per lifetime. Following the final oocyte retrieval, benefits will be provided for one subsequent procedure to transfer the oocytes or sperm to the Covered Person.	The amount you pay is based on where the covered health service is provided. Prior Authorization is required.
Lab, X-Ray and Diagnostics - Outpatient	
	30% co-insurance, after the medical deductible has been met.
Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	
	30% co-insurance, after the medical deductible has been met.

Your Costs

Common Medical Event	Your cost if you use Network Benefits
Mental Health Services	
Inpatient:	30% co-insurance, after the medical deductible has been met.
Outpatient:	30% co-insurance, after the medical deductible has been met.
Partial Hospitalization/Intensive Outpatient Treatment:	30% co-insurance, after the medical deductible has been met.
Naprapathic Services	
Limited to 15 visits per year.	30% co-insurance, after the medical deductible has been met (with a referral from your Primary Physician).
Neurobiological Disorders – Autism Spectrum Disorder Services	
Inpatient:	30% co-insurance, after the medical deductible has been met.
Outpatient:	30% co-insurance, after the medical deductible has been met.
Partial Hospitalization/Intensive Outpatient Treatment:	30% co-insurance, after the medical deductible has been met.
Obesity Surgery	
Obesity surgery is covered when received at a designated facility. Designated services are provided by Bariatric Resource Services, a program for surgical weight loss solutions.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Ostomy Supplies	
Limited to $2,500 per year.	30% co-insurance, after the medical deductible has been met.
Pharmaceutical Products - Outpatient	
This includes medications given at a doctor's office, or in a Covered Person's home.	30% co-insurance, after the medical deductible has been met.
Physician Fees for Surgical and Medical Services	
	30% co-insurance, after the medical deductible has been met for services provided by your Primary Physician, Network obstetrician or gynecologist. 30% co-insurance, after the medical deductible has been met (with a referral from your Primary Physician).
Physician's Office Services - Sickness and Injury	
	30% co-insurance, after the medical deductible has been met for services provided by your Primary Physician, Network obstetrician or gynecologist. 30% co-insurance, after the medical deductible has been met (with a referral from your Primary Physician).

Your Costs

Common Medical Event	Your cost if you use Network Benefits
Pregnancy - Maternity Services	
	The amount you pay is based on where the covered health service is provided.
Prescription Drug Benefits	
Prescription drug benefits are shown in the Prescription Drug benefit summary.	
Preventive Care Services	
Physician Office Services, Scopic Procedures, Lab, X-Ray or other preventive tests.	You pay nothing for services provided by your Primary Physician, Network obstetrician or gynecologist (with a referral from your Primary Physician). A deductible does not apply.
Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a co-pay, co-insurance or deductible.	
Private Duty Nursing	
	30% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Prosthetic Devices	
	30% co-insurance, after the medical deductible has been met.
Reconstructive Procedures	
	The amount you pay is based on where the covered health service is provided.
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment	
	30% co-insurance, after the medical deductible has been met for manipulative treatment (with a referral from your Primary Physician). 30% co-insurance, after the medical deductible has been met (for all other rehabilitation services).
Scopic Procedures - Outpatient Diagnostic and Therapeutic	
Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.	30% co-insurance, after the medical deductible has been met for services provided by your Primary Physician, Network obstetrician or gynecologist. 30% co-insurance, after the medical deductible has been met (with a referral from your Primary Physician).
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services	
	30% co-insurance, after the medical deductible has been met.

Your Costs

Common Medical Event	Your cost if you use Network Benefits
Substance Use Disorder Services	
Inpatient:	30% co-insurance, after the medical deductible has been met.
Outpatient:	30% co-insurance, after the medical deductible has been met.
Partial Hospitalization/Intensive Outpatient Treatment:	30% co-insurance, after the medical deductible has been met.
Surgery - Outpatient	
	30% co-insurance, after the medical deductible has been met for services provided by your Primary Physician, Network obstetrician or gynecologist. 30% co-insurance, after the medical deductible has been met (with a referral from your Primary Physician).
Temporomandibular Joint Services and Craniomandibular Disorder	
	The amount you pay is based on where the covered health service is provided.
Therapeutic Treatments - Outpatient	
Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.	30% co-insurance, after the medical deductible has been met.
Transplantation Services	
Network Benefits must be received at a designated facility.	The amount you pay is based on where the covered health service is provided. Prior Authorization is required.
Urgent Care Center Services	
	30% co-insurance, after the medical deductible has been met.
Virtual Visits	
Benefits are available only when services are delivered through a Designated Virtual Network Provider. Find a Designated Virtual Network Provider at myuhc.com or by calling Customer Care at the telephone number on your ID card.	30% co-insurance, after the medical deductible has been met.

Common Medical Event	Your cost if you use Network Benefits
Vision - Pediatric Services (Benefits covered up to age)	
Find a listing of Spectera Eyecare Network Vision Care Providers at myuhcvision.com.	
Routine Vision Examination Limited to once every 12 months.	You pay nothing. A deductible does not apply.
Eyeglass Lenses Limited to once every 12 months.	You pay nothing, after the medical deductible has been met.
Lens Extras Limited to once every 12 months. Coverage includes polycarbonate lenses and standard scratch-resistant coating.	You pay nothing, after the medical deductible has been met.
Eyeglass Frames Limited to once every 12 months.	
Eyeglass frames with a retail cost up to $130.	You pay nothing, after the medical deductible has been met.
Eyeglass frames with a retail cost between $130 - 160.	You pay nothing, after the medical deductible has been met.
Eyeglass frames with a retail cost between $160 - 200.	You pay nothing, after the medical deductible has been met.
Eyeglass frames with a retail cost between $200 - 250.	You pay nothing, after the medical deductible has been met.
Eyeglass frames with a retail cost greater than $250.	You pay nothing, after the medical deductible has been met.
Contact Lenses/Necessary Contact Lenses You may choose contact lenses instead of eyeglasses. The benefit doesn't cover both. Limited to a 12 month supply. Find a complete list of covered contacts at myuhcvision.com.	You pay nothing, after the medical deductible has been met.
Low Vision Services Limited to a 24 month frequency, or every 6 months when low vision conditions occur.	You pay nothing for Low Vision Testing. A deductible does not apply. 25% co-insurance for Low Vision Therapy. A deductible does not apply.

Services your plan does not cover (Exclusions)

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

Alternative Treatments

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

Dental

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

Services your plan does not cover (Exclusions)

Dental - Pediatric Services

Benefits are not provided under Pediatric Dental Services for the following: Any Dental Service or Procedure not listed as a Covered Pediatric Dental Service. Hospitalization or other facility charges. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.) Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, Injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body. Any Dental Procedure not directly associated with dental disease. Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision. Replacement of complete dentures, fixed and removable partial dentures or crowns and implants, implant crowns and prosthesis if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint. Benefits for the orthognathic surgery services are considered medical in nature and, depending upon where the Covered Health Services are provided, are described under the applicable Benefit category in the Certificate in Section 1: Covered Health Services and in the Schedule of Benefits. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice. Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled for coverage provided through this section. Dental Services otherwise covered under the Policy, but rendered after the date individual coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy terminates. Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child. Foreign Services are not covered unless required as an Emergency. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO). Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service. Partial dentures are covered only for recipients with good health and hygiene, good periodontal health (AAP Type I or II), and a favorable prognosis where continuous deterioration is not expected. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan. Dental Services from a non-Network Dental Provider.

Devices, Appliances and Prosthetics

Devices used specifically as safety items or to affect performance in sports-related activities. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. This exclusion does not apply to orthotic devices as described under the Customized Orthotic Devices provision in Section 1 of the COC. The following items are excluded, even if prescribed by a Physician: blood pressure cuff/monitor; enuresis alarm; non-wearable external defibrillator; trusses and ultrasonic nebulizers. Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophogeal voice devices for which Benefits are provided as described under Durable Medical Equipment in Section 1 of the COC. Oral appliances for snoring. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

Services your plan does not cover (Exclusions)

Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office. Over-the-counter drugs and treatments. Growth hormone therapy. New Pharmaceutical Products and/or new dosage forms until the date they are reviewed. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year. 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. 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. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year.

Experimental, Investigational or Unproven Services

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

Foot Care

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

Medical Supplies

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

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

Tubing and masks, except when used with Durable Medical Equipment as described under Durable Medical Equipment in Section 1 of the COC.

Mental Health, Neurobiological/Autism Spectrum, and Substance Use Disorders

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, pyromania, kleptomania, gambling disorder, and paraphilic disorder. Educational services that are focused on primarily building skills and capabilities in communication, social interaction and learning. Tuition or services that are school-based for children and adolescents required to be provided by, or paid for, by the school under the Individuals with Disabilities Education Act. Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Transitional Living services.

Nutrition

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 amino acid-based elemental formulas or medical 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 an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Enteral feedings, even if the sole source of nutrition. Infant formula and donor breast milk. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods).

Personal Care, Comfort or Convenience

Television; telephone; beauty/barber service; guest service. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include: air conditioners, air purifiers and filters, dehumidifiers; batteries and battery chargers; breast pumps (This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement); car seats; chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners; exercise equipment; home modifications such as elevators, handrails and ramps; hot 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.

Physical Appearance

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

Services your plan does not cover (Exclusions)

Procedures and Treatments

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

Providers

Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. Services performed by a provider with your same legal residence. Services provided at a 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 or 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 actively involved in your medical care prior to ordering the service, or is not actively involved in your medical care after the service is received. This exclusion does not apply to mammography.

Reproduction

The reversal of voluntary sterilization; however, in the event a voluntary sterilization is successfully reversed, Infertility benefits shall be available if the Covered Person's diagnosis meets the definition of Infertility. Payment for services rendered to a surrogate (however, costs for procedures to obtain eggs, sperm or embryos from a Covered Person will be covered if the individual chooses to use a surrogate); Costs associated with cryo preservation and storage of sperm, eggs, and embryos; provided, however, subsequent procedures of a medical nature necessary to make use of the cryo preserved substance shall not be similarly excluded if deemed non-experimental and non-investigational; Selected termination of an embryo; provided, however, that where the life of the mother would be in danger were all embryos to be carried to full term, the termination would be covered; Non-medical costs of an egg or sperm donor; 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, where Infertility treatment includes elements which are not experimental in nature along with those which are, to the extent services may be delineated and separately charged, those services which are not experimental in nature shall be covered; Infertility treatments rendered to dependents under the age of 18.

Services your plan does not cover (Exclusions)

Services Provided under Another Plan

Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. 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. 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. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.

Transplants

Health services for organ and tissue transplants, except those described under Transplantation Services in Section 1 of the COC. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.) Health services for transplants involving permanent mechanical or animal organs. Transplant services that are not performed at a Designated Facility. This exclusion does not apply to cornea transplants.

Travel

Health services provided in a foreign country, unless required as Emergency Health Services. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed as determined by us. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under Ambulance Services in Section 1 of the COC.

Types of Care

Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain. Custodial care or maintenance care; domiciliary care. Private Duty Nursing except when required on a home basis as described in this section. Private Duty Nursing services in an Inpatient setting remain excluded. In addition, Benefits for Private Duty Nursing exclude the following: Services provided to a Covered Person by an Independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing. Services once the patient or caregiver are trained to perform care safely. Services for the comfort or convenience of the Covered Person or the Covered Person's caregiver. Services that are custodial in nature (Custodial Care). Intermittent care. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under Hospice Care in Section 1 of the COC. Rest cures; services of personal care attendants. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

Purchase cost and fitting charge for eye glasses and contact lenses. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants). Eye exercise or vision therapy. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser, and other refractive eye surgery. Bone anchored hearing aids except when either of the following applies: For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid. For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. Routine vision examinations, including refractive examinations to determine the need for vision correction.

Vision - Pediatric Services

Benefits are not provided under Pediatric Vision Services for the following: Medical or surgical treatment for eye disease which requires the services of a Physician and for which Benefits are available as stated in the COC. Non-prescription items (e.g. Plano lenses). Replacement or repair of lenses and/or frames that have been lost or broken.

Services your plan does not cover (Exclusions)

Optional Lens Extras not listed in Vision Care Services. Missed appointment charges. Applicable sales tax charged on Vision Care Services. Vision Care Services received from a non-Spectera Eyecare Networks Vision Care Provider.

All Other Exclusions

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

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