OPTIMUM CHOICE, Inc.
A UnitedHealthcare Company

Benefit Summary

Silver OCI Preferred HSA 2300
Virginia - Optimum Choice Preferred
Optimum Choice Preferred Direct HSA - Plan ACSK

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 Optimum Choice Preferred Direct Plan with an HSA?

Get more protection with a national network and save with Tier 1 providers and an HSA.

A network is a group of health care providers and facilities that have a contract with the health plan. You can receive care from anyone in or out of our network, but you can save more money when you use the network. You can save even more when you use Tier 1 providers. 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.

> **Pay less by using certain freestanding centers.** Freestanding centers are health care facilities that do not bill for services as part of a hospital, such as MRI or surgery centers.

> **There's coverage if you need to go out of the network.** Choose what's best for you. Just remember out-of-network providers will likely charge you more.

> **Referrals are not required to see a specialist.** But if you don't obtain a referral your benefit will be paid at the out of network level.

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

Not enrolled yet? Search for network doctors or hospitals at **welcometouhc.com** 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-payment (Your cost for an office visit)	Individual Deductible (Your cost before the plan starts to pay)	Co-insurance (Your cost share after the deductible)
$25	$2,300	You have no co-insurance.

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.

Optimum Choice, Inc. and MAMSI Life and Health Insurance Company

Your Costs

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

	Your cost if you use Network Benefits	Your cost if you use Preferred and Non-Preferred Out-of-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. > No one in the family is eligible for benefits until the family coverage deductible is met.		
Medical Deductible - Single Coverage	$2,300 per year	$4,000 per year
Medical Deductible - Family Coverage	$5,750 per year	$8,000 per year
Dental - Pediatric Services Deductible - Single Coverage	$100 per year	Included in your medical deductible.
Dental - Pediatric Services Deductible - Family Coverage	$200 per year	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, deductibles and per occurrence deductibles (including pharmacy) count towards meeting the out-of-pocket limit. > If more than one person in a family is covered under the Policy, the single coverage out-of-pocket limit does not apply.		
Out-of-Pocket Limit - Single Coverage	$6,500 per year	$8,000 per year
Out-of-Pocket Limit - Family Coverage	$6,850 per year	$16,000 per year

Your Costs

What is co-insurance?

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

What is a co-payment?

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

What is Prior Authorization?

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

Want more information?

Find additional definitions in the glossary at justplainclear.com.

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	Your cost if you use Preferred and Non-Preferred Out-of-Network Benefits
Acupuncture Services		
Limited to 12 visits per year.	You pay nothing, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.
Ambulance Services - Emergency and Non-Emergency		
	You pay nothing, after the medical deductible has been met.	Emergency: You pay nothing, after the network medical deductible has been met. Non-Emergency: 20% co-insurance, after the medical deductible has been met. Precertification is required for Non-Emergency Ambulance.
Chiropractic Services		
Limited to 30 visits per year.	$25 co-pay per visit, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.
Clinical Trials		
	The amount you pay is based on where the covered health service is provided.	Preadmission Authorization is required.
Congenital Defects and Birth Abnormalities		
	The amount you pay is based on where the covered health service is provided.	Precertification is required.
Congenital Heart Disease (CHD) Surgeries		
	$500 co-pay per Inpatient Stay, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met. Preadmission Authorization is required.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Preferred and Non-Preferred Out-of-Network Benefits
Dental - Pediatric Services (Benefits covered up to age 19)		
Benefits provided by the National Options PPO 30 Network (PPO-UCR 50th).		
Dental - Pediatric Preventive Services		
Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.	You pay nothing, after the dental services deductible has been met.	You pay nothing, after the medical deductible has been met.
Fluoride Treatments Limited to 2 times per 12 months.	You pay nothing, after the dental services deductible has been met.	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 dental services deductible has been met.	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 dental services deductible has been met.	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 dental services deductible has been met.	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 dental services deductible has been met.	You pay nothing, after the medical deductible has been met.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Preferred and Non-Preferred Out-of-Network Benefits
Dental - Pediatric Basic Dental Services		
Endodontics (Root Canal Therapy)	20% co-insurance, after the dental services deductible has been met.	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 dental services deductible has been met.	20% co-insurance, after the medical deductible has been met.
Oral Surgery (Including Surgical Extractions)	20% co-insurance, after the dental services deductible has been met.	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, exclusive of gross debridement.	20% co-insurance, after the dental services deductible has been met.	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 dental services deductible has been met.	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 dental services deductible has been met.	20% co-insurance, after the medical deductible has been met.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Preferred and Non-Preferred Out-of-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 dental services deductible has been met.	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 dental services deductible has been met.	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 dental services deductible has been met.	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 dental services deductible has been met.	50% co-insurance, after the medical deductible has been met.
Dental - Pediatric Medically Necessary Orthodontics		
Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/ vertical (overjet/overbite) discrepancies.	50% co-insurance, after the dental services deductible has been met.	50% co-insurance, after the medical deductible has been met.
	Prior Authorization required for orthodontic treatment.	Prior Authorization required for orthodontic treatment.
Dental Services - Accident Only		
	The amount you pay is based on where the covered health service is provided.	
		Precertification is required.
Dental Services - Adjunctive		
	The amount you pay is based on where the covered health service is provided.	
		Precertification is required.
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 Amendment.	

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Preferred and Non-Preferred Out-of-Network Benefits
Durable Medical Equipment		
	You pay nothing, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met. Precertification is required.
Early Intervention Services		
	The amount you pay is based on where the covered health service is provided.	 Precertification is required.
Emergency Health Services - Outpatient		
	$150 co-pay per visit, after the medical deductible has been met.	$150 co-pay per visit, after the network medical deductible has been met.
Hearing Aids		
Limited to $2,500 per year and a single purchase (including repair and replacement) per hearing impaired ear every 3 years.	You pay nothing, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met. Precertification is required.
Home Health Care		
Limited to 100 visits per year. In accordance with Virginia law and as described in the Certificate of Coverage, Benefits are provided for one postpartum home visit or visits following obstetrical care in a Hospital, as prescribed by a Physician. Such visits are not subject to this visit limit.	You pay nothing, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.
Home Treatment of Hemophilia And Congenital Bleeding Disorders		
	The amount you pay is based on where the covered health service is provided.	 Precertification is required.
Hospice Care		
	You pay nothing, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Preferred and Non-Preferred Out-of-Network Benefits
Hospital - Inpatient Stay		
	$500 co-pay per Inpatient Stay, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met. Preadmission Authorization is required.
Infertility Services		
Limited to a maximum of six cycles of artificial insemination per Covered Person during the entire period of time she is enrolled for coverage under the Policy.	You pay nothing, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.
Lab, X-Ray and Diagnostics - Outpatient		
	You pay nothing, after the medical deductible has been met for services provided at an alternate facility. You pay nothing, after the medical deductible has been met for services provided at a hospital.	20% co-insurance, after the medical deductible has been met for services provided an alternate facility. 20% co-insurance, after the medical deductible has been met for services provided at a hospital.
Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient		
	You pay nothing, after the medical deductible has been met for services provided at an alternate facility. $250 per occurrence deductible per service, after the medical deductible has been met for services provided at a hospital.	20% co-insurance, after the medical deductible has been met for services provided at an alternate facility. 20% co-insurance, after the medical deductible has been met for services provided at a hospital.
Medical Formulas		
	You pay nothing, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Preferred and Non-Preferred Out-of-Network Benefits
Mental Health Services		
Inpatient:	$500 co-pay per Inpatient Stay, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.
Outpatient: When outpatient visits are subject to payment of a co-payment, the co-payment will not exceed 50% of Eligible Expenses.	$50 co-pay per visit, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.
Partial Hospitalization/Intensive Outpatient Treatment:	You pay nothing, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met. Preadmission Authorization is required for certain services.
Neurobiological Disorders – Autism Spectrum Disorder Services		
Inpatient:	$500 co-pay per Inpatient Stay, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.
Outpatient: When outpatient visits are subject to payment of a co-payment, the co-payment will not exceed 50% of Eligible Expenses.	$50 co-pay per visit, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.
Partial Hospitalization/Intensive Outpatient Treatment:	You pay nothing, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met. Preadmission Authorization is required for certain services.
Ostomy and Urologic Supplies		
	You pay nothing, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met. Precertification is required.
Physician Fees for Surgical and Medical Services		
	You pay nothing, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.
Physician's Office Services - Sickness and Injury		
Primary Physician Office Visit	$25 co-pay per visit, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.
Specialist Physician Office Visit	$50 co-pay per visit, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Preferred and Non-Preferred Out-of-Network Benefits
Pregnancy - Maternity Services		
	The amount you pay is based on where the covered health service is provided.	
		Preadmission Authorization is required.
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. A deductible does not apply.	20% co-insurance, after the medical deductible has been met.
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 - Home Services		
Limited to 2 visits per year.	You pay nothing, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.
		Precertification is required.
Prosthetic Devices		
	You pay nothing, after the medical deductible has been met.	20% 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.	
		Preadmission Authorization is required for certain services.
Rehabilitation and Habilitative Services		
30 visits of physical therapy and occupational therapy combined. 30 visits of speech therapy. 20 visits of outpatient pulmonary rehabilitation. Note: Rehabilitation Services in connection with the Early Intervention Services Benefit are not subject to the limits stated above.	The amount you pay is based on where the covered health service is provided.	
		Precertification is required for certain services.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Preferred and Non-Preferred Out-of-Network Benefits
Scopic Procedures - Outpatient Diagnostic and Therapeutic		
Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.	You pay nothing, after the medical deductible has been met for services provided at a free-standing center or in a physician's office. $250 per occurrence deductible per date of service, after the medical deductible has been met for services provided at an outpatient hospital-based center.	20% co-insurance, after the medical deductible has been met for services provided at a free-standing center or in a physician's office. 20% co-insurance, after the medical deductible has been met for services provided at an outpatient hospital-based center.
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services		
Limited to 100 days per stay.	$500 co-pay per Inpatient Stay, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.
Substance Use Disorder Services		
Inpatient:	$500 co-pay per Inpatient Stay, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.
Outpatient: When outpatient visits are subject to payment of a co-payment, the co-payment will not exceed 50% of Eligible Expenses.	$50 co-pay per visit, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.
Partial Hospitalization/Intensive Outpatient Treatment:	You pay nothing, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met. Preadmission Authorization is required for certain services.
Surgery - Outpatient		
	You pay nothing, after the medical deductible has been met for services provided at an alternate facility. $250 per occurrence deductible per date of service, after the medical deductible has been met for services provided at a hospital.	20% co-insurance, after the medical deductible has been met for services provided at an alternate facility. 20% co-insurance, after the medical deductible has been met for services provided at a hospital.
Temporomandibular Disorder Services		
	The amount you pay is based on where the covered health service is provided.	Preadmission Authorization is required.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Preferred and Non-Preferred Out-of-Network Benefits
Therapeutic Treatments - Outpatient		
Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.	You pay nothing, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met. Precertification is required.
Transplantation Services		
Network Benefits must be received at a designated facility and Preferred Out of Network Benefits must be received at a Network facility.	The amount you pay is based on where the covered health service is provided.	Preadmission Authorization is required.
Urgent Care Center Services		
	$75 co-pay per visit, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.
Virtual Visits		
Network Benefits are available only when services are delivered through a Designated Virtual Visit Network Provider. Find a Designated Virtual Visit Network Provider Group at myuhc.com or by calling Customer Care at the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.	$25 co-pay per visit, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Preferred and Non-Preferred Out-of-Network Benefits
Vision - Pediatric Services (Benefits covered up to age 19)		
Find a listing of Spectera Eyecare Network Vision Care Providers at myuhcvision.com.		
Routine Vision Examination Limited to once every 12 months.	$25 co-pay per visit. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Eyeglass Lenses Limited to once every 12 months. Coverage includes polycarbonate lenses and standard scratch-resistant coating.	50% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Eyeglass Frames Limited to once every 12 months.		
Eyeglass frames with a retail cost up to $130.	50% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Eyeglass frames with a retail cost between $130 - 160.	50% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Eyeglass frames with a retail cost between $160 - 200.	50% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Eyeglass frames with a retail cost between $200 - 250.	50% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Eyeglass frames with a retail cost greater than $250.	50% co-insurance, after the medical deductible has been met.	50% co-insurance, 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.	50% co-insurance, after the medical deductible has been met.	50% co-insurance, 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.	25% co-insurance for Low Vision Testing, after the medical deductible has been met. 25% co-insurance for Low Vision Therapy, after the medical deductible has been met.
Vision Correction After Surgery or Accident		
	You pay nothing, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met. Precertification is required.
Vision Examination (Benefit is for Covered Persons over age 19)		
Find a listing of Spectera Eyecare Network Vision Care Providers at myuhcvision.com.		

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Preferred and Non-Preferred Out-of-Network Benefits
Limited to 1 exam every 12 months.	$25 co-pay per visit. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.

Services your plan does not cover (Exclusions)

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

Alternative Treatments

Acupressure; aromatherapy; hypnotism; massage therapy; rolfing; alternative medical equipment, devices and supplies such as magnets or massage devices, herbs, and vitamins; biofeedback equipment; 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 Chiropractic Services and non-manipulative osteopathic care for which Benefits are provided as described in Section 1 of the COC.

Dental

Routine dental treatment, X-rays, preventive care, diagnosis, and treatment of or related to teeth, their supporting structures (including the jawbones) and gums, except as described under Dental Services-Adjunctive in Section 1 of the COC. Examples include the following: extraction, restoration and replacement of teeth; medical or surgical treatments of dental conditions; and services to improve dental clinical outcomes. Dental implants and bone grafts related to implant placement. Orthodontic correction of malocclusion.

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. Dental Services that are not Necessary. 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. Any Dental Procedure not performed in a dental setting. 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 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. 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 the Rider to the Policy. 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. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction. 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. 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.

Services your plan does not cover (Exclusions)

Devices, Appliances and Prosthetics

Devices used specifically as safety items or to affect performance in sports-related activities. Foot orthotics and over-the-counter orthotic braces. Cranial banding except when Medically Necessary to correct a Congenital Anomaly. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures; all over-the-counter medical equipment or devices defined as items which can be typically purchased at (including, but not limited to) a local pharmacy, supermarket, internet site, general publication or medical supply storefront and do not require a Physician's prescription for purchase. The following items are excluded, even if prescribed by a Physician: blood pressure cuff/monitor; home therapeutic monitoring devices such as "Coagucheck"; enuresis alarm and other bed wetting control devices, drionic (anti-sweat) devices; non-wearable external defibrillator; trusses and ultrasonic nebulizers unless Medically Necessary. If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the equipment that meets the minimum specifications for your needs; mobility chairs or strollers if a manual or power wheelchair is the primary means of mobility and is owned or rented by the Covered Person. Duplicate, backup or alternative equipment such as manual wheelchairs that back up power wheelchairs (the Covered Person's primary means of mobility) or a second nebulizer machine for portability; parts and labor costs for supplies and accessories replaced due to wear and tear, such as wheelchair tires, tubes, brakes or upholstery; scooters (power operated vehicles). Car seats; home and vehicle modifications; seat lifts, chairs and lift mechanisms. Stethoscopes; external penile devices, erectaid. Cold therapy devices, icepacks, heating pads or thermal wraps; whirlpools, wax treatment/paraffin baths; cervical, thoracic, lumbar or sacral pillows, wedges, supports or cushions. Physical fitness equipment, massage tables, inversion tables; ergonomic office equipment; aids for activities of daily living such as transfer benches, grab bars, reachers, utensil holders, button zipper pulls. Personal hygiene equipment or devices such as toileting systems or hygienic assistive devices such as bath tub lifts or seats or raised toilet seats; standing tables, adaptive positioning and assistive technology devices. Equipment and devices designed to improve self image or self esteem. Devices and computers to assist in communication and speech except for Medically Necessary speech generating devices and speech aid devices that meet the definition of Durable Medical Equipment in Section 1 of the COC. Equipment for which the primary function is vocationally or educationally related, such as Braille training text. 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. Appliances for temporomandibular disorder (TMD) pain dysfunction.

Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill. Self-injectable medications. Non-injectable medications given in a Physician’s office. This exclusion does not apply to non-injectable medications that are required in an Emergency. Over-the-counter drugs and treatments. Growth hormone therapy, unless for the treatment of a primary growth hormone deficiency.

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. However, no prescribed drug shall be excluded as an Experimental or Investigational or Unproven Service on the basis that the drug has not been approved by the Food and Drug Administration (FDA) for the treatment of the specific condition for which the drug has been prescribed provided that (1) the drug has been approved by the FDA for at least one indication and (2) the drug has been recognized as safe and effective for the treatment of the specific condition in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature. Additionally, Benefits shall not be excluded for any drug approved by the Food and Drug Administration for use in the treatment of cancer pain on the basis that the dosage is in excess of the recommended dosage of the pain-relieving agent, if the prescription in excess of the recommended dosage has been prescribed in compliance with Virginia law for a patient with intractable cancer pain. 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.

Services your plan does not cover (Exclusions)

Foot Care

Routine foot care. This exclusion does not apply to preventive foot care for Covered Persons with diabetes. Routine 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; other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot. 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. Shoe orthotics and orthopedic shoes, except therapeutic shoes for Covered Person with diabetes for which Benefits are provided as described under Durable Medical Equipment in Section 1 of the COC; 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, incontinent pads and diapers. 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.
- Ostomy and urologic supplies for which Benefits are provided as described under Ostomy and Urologic Supplies in Section 1 of the COC.
- Blood infusion equipment for which Benefits are provided as described under Home Treatment of Hemophilia and Congenital Blood Disorders 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. All over-the-counter supplies defined as items which can be typically purchased at (including, but not limited to) a local pharmacy, supermarket, internet site, general publication or medical supply storefront and do not require a Physician's prescription for purchase.

Mental Health

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Mental Health Services as treatments for R & T code conditions as listed within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep-wake disorders, feeding disorders, binge eating disorders, sexual dysfunction, communication disorders, motor disorders, neurological disorders and other disorders with a known physical basis. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilic disorder. Educational services that are focused on primarily building skills and capabilities in communication, social interaction and learning. Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act. Motor disorders and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Intellectual disabilities as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Autism spectrum disorder as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Benefits for autism spectrum disorder as a primary diagnosis are described under Neurobiological Disorders - Autism Spectrum Disorder Services in Section 1 of the COC. Mental Health Services as a treatment for other conditions that may be a focus of clinical attention as listed in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. All unspecified disorders in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 9 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

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

Services your plan does not cover (Exclusions)

Neurobiological Disorders – Autism Spectrum Disorder

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

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

Nutrition

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

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

Nutritional or dietary supplements, except as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over-the-counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist. 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 (including those used with Durable Medical Equipment); 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, posture chairs, floor sitters, recliners; exercise equipment; home modifications such as elevators, handrails, stair lifts and ramps; hot tubs; humidifiers; Jacuzzis; mattresses; medical alert systems; motorized beds; music devices; personal computers, pillows; power-operated vehicles; radios; saunas; scales; stair lifts and stair glides; strollers; safety equipment; treadmills; vehicle modifications such as van lifts; video players, wheel chair desks, whirlpools.

Services your plan does not cover (Exclusions)

Physical Appearance

Cosmetic Procedures. See the definition in Section 9 of the COC. Examples include: pharmacological regimens, nutritional procedures or treatments. Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). Skin abrasion procedures performed as a treatment for acne. Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. Treatment for skin wrinkles or any treatment to improve the appearance of the skin. Treatment for spider veins. Hair removal or replacement by any means. Rhinoplasty or septorhinoplasty unless Medically Necessary; sclerotherapy performed on the arms, legs, feet or hands unless Medically Necessary. 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. Surgical treatment of gynecomastia for cosmetic purposes. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded. Wigs regardless of the reason for the hair loss.

Procedures and Treatments

Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, and brachioplasty. Medical and surgical treatment of excessive sweating (hyperhidrosis). Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. Routine rehabilitation services and Chiropractic Services to improve general physical condition or reduce potential risk factors, including routine preventive treatments. Group speech therapy. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident. Psychosurgery. Sex transformation operations and related services. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter. Upper and lower jawbone surgery, and jaw alignment. This exclusion does not apply to direct treatment of temporomandibular disorder and/or related myofascial pain dysfunction syndrome or to reconstructive jaw surgery required for Covered Persons because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea. Orthognathic surgery except as described under Dental Services-Adjunctive in Section 1 of the COC. Surgical and non-surgical treatment of obesity. Smoking cessation programs not affiliated with us. Breast reduction surgery except as coverage is required by the Women's Health and Cancer Rights Act of 1998 for which Benefits are described under Reconstructive Procedures in Section 1 of the COC. In vitro fertilization regardless of the reason for treatment.

Providers

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

Reproduction

The following infertility treatment-related services: In vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT); cryo-preservation and other forms of preservation of reproductive materials; long-term storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue; donor services; all infertility services after voluntary sterilization or reversal of voluntary sterilization of either partner; Infertility services for a non-covered spouse or partner; sex selection, gene therapy, genetic alteration, genetic testing of embryos prior to implantation. Surrogate parenting, donor eggs, donor sperm and host uterus; storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue. The reversal of voluntary sterilization.

Services your plan does not cover (Exclusions)

Services Provided under Another Plan

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

Substance Use Disorders

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents. Educational services that are focused on primarily building skills and capabilities in communication, social interaction and learning. Substance-induced sexual dysfunction disorders and substance-induced sleep disorders. Gambling disorders. All unspecified disorders in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 9 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

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

Transplants

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

Travel

Health services provided in a foreign country, unless required as Emergency Health Services. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at our discretion. 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 on an inpatient basis. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under Hospice Care in Section 1 of the COC. Rest cures; services of personal care attendants. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Services your plan does not cover (Exclusions)

Vision and Hearing

Purchase cost and fitting charge for eye glasses and contact lenses. This exclusion does not apply to benefits for glasses or contact lenses as described under Vison Correction After Surgery or Accident in Section 1 of the COC. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants). Eye exercise or vision therapy. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser, and other refractive eye surgery. Bone anchored hearing aids except when either of the following applies: For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid. For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. More than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled under the Policy. Repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage criteria, other than for malfunctions.

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. Optional Lens Extras not listed in Vision Care Services. Missed appointment charges. Applicable sales tax charged on Vision Care Services.

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