UnitedHealthcare®

Benefit Summary

Gold Choice Plus 1500-20
Maryland - Choice Plus
Choice Plus Direct - Plan AELF

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 Choice Plus Direct Plan?

> **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.** Out-of-network means that a provider does not have a contract with us. Choose what's best for you. Just remember out-of-network providers will likely charge you more.

> **There's no need to choose a primary care provider (PCP) or get referrals to see a specialist.** Consider a PCP; they can be helpful in managing your care.

> **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)
$20	$1,500	20%

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 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 Out-of-Network Benefits
Deductible		

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.

> Your co-pays don't count towards meeting the deductible unless otherwise described within the specific common medical event.

> 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.

> This benefit plan includes a per occurrence deductible that applies to certain common medical events. This per occurrence deductible must be met prior to and in addition to the medical deductible.

	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Medical Deductible - Individual	$1,500 per year	$2,000 per year
Medical Deductible - Family	$3,000 per year	$4,000 per year
Dental - Pediatric Services Deductible - Individual	Included in your medical deductible.	Included in your medical deductible.
Dental - Pediatric Services Deductible - Family	Included in your medical deductible.	Included in your medical deductible.

Out-of-Pocket Limit

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.

> 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.

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

	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Out-of-Pocket Limit - Individual	$3,000 per year	$6,000 per year
Out-of-Pocket Limit - Family	$6,000 per year	$12,000 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 Out-of-Network Benefits
Ambulance Services		
	20% co-insurance, after the medical deductible has been met. Prior Authorization is required for Non-Emergency Ambulance.	<a>/benefitnamevalue.sql Amb_Tier1_NN Error: Amb_Tier1_NN Not Found. Prior Authorization is required for Non-Emergency Ambulance.
Blood and Blood Products		
	20% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Case Management Services		
	The amount you pay is based on where the covered health service is provided.	
Chiropractic Services		
Limited to 20 visits per year.	$20 co-pay per visit. A deductible does not apply.	20% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Controlled Clinical Trials		
	The amount you pay is based on where the covered health service is provided. Prior Authorization is required.	Prior Authorization is required.
Dental - Pediatric Services (Benefits covered up to age 19)		

Benefits provided by the National Options PPO 30 Network (PPO-UCR 50th).

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Dental - Pediatric Preventive Services		
Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.	You pay nothing, after the medical deductible has been met.	You pay nothing, after the medical deductible has been met.
Fluoride Treatments Limited to 4 times per 12 months for Covered Persons age 3 years and older. Limited to 8 times per 12 months for Covered Persons age 0 to 2 years.	You pay nothing, after the medical deductible has been met.	You pay nothing, after the medical deductible has been met.
Sealants (Protective Coating) Limited to 1 per lifetime per Covered Person per tooth.	You pay nothing, after the medical deductible has been met.	You pay nothing, after the medical deductible has been met.
Space Maintainers Limited to 1 per 24 months per quadrant. Benefit includes all adjustments within 6 months of installation.	You pay nothing, after the medical 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 medical deductible has been met.	You pay nothing, after the medical deductible has been met.
Radiographs	You pay nothing, after the medical 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 Out-of-Network Benefits
Dental - Pediatric Basic Dental Services		
Endodontics (Root Canal Therapy)	20% co-insurance, after the medical 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.	20% co-insurance, after the medical deductible has been met.	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.	20% co-insurance, after the medical deductible has been met.
Periodontics Periodontal Surgery: Limited to 1 quadrant or site per 24 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 medical 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 medical deductible has been met.	20% co-insurance, after the medical deductible has been met.
Simple Extractions (Simple tooth removal)	20% co-insurance, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.
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.	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.	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.	50% 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 Out-of-Network Benefits
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 medical 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 - Hospital and Ambulatory Facility Charges Related to Dental Care		
	Inpatient: 20% co-insurance, after the medical deductible has been met.	Inpatient: 30% co-insurance, after the medical deductible has been met.
	Outpatient: $50 co-pay per visit. A deductible does not apply.	Outpatient: 20% co-insurance, after the medical deductible has been met.
		Prior Authorization is required for certain services.
Detoxification Services		
	Inpatient: 20% co-insurance, after the medical deductible has been met.	Inpatient: 30% co-insurance, after the medical deductible has been met.
	Outpatient Office Visits: $50 co-pay per visit. A deductible does not apply.	Outpatient Office Visits: 20% co-insurance, after the medical deductible has been met.
	All Other Outpatient Services: 20% co-insurance, after the medical deductible has been met.	All Other Outpatient Services: 30% co-insurance, after the medical deductible has been met.
Diabetes Treatment, Equipment and Supplies		
Diabetes Treatment, Equipment and Supplies	The amount you pay is based on where the covered health service is provided.	
		Prior Authorization is required for Durable Medical Equipment that costs more than $1,000.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Durable Medical Equipment		
To receive Network Benefits, you must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	20% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for Durable Medical Equipment that costs more than $1,000.
Emergency Health Services		
	20% co-insurance, after the medical deductible has been met.	20% co-insurance, after the network medical deductible has been met. Notification is required if confined in an Out-of-Network Hospital.
Family Planning Services		
	$20 co-pay per visit for a Primary Physician office visit or $50 co-pay per visit for a Specialist Physician office visit. A deductible does not apply.	20% co-insurance, after the medical deductible has been met.
Habilitative Services		
For Covered Persons age 19 and older benefits are limited as follows: 30 visits of physical therapy visits per condition. 30 visits of speech therapy visits per condition. 30 visits of occupational therapy visits per condition.	$20 co-pay per visit. A deductible does not apply.	20% co-insurance, after the medical deductible has been met.
Hearing Aids		
Limited to a single purchase (including repair and replacement) per hearing impaired ear every 3 years.	20% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Home Health Care Services		
	20% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Hospice Care Services		
	20% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for Inpatient Stay.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Infertility Services		
	20% co-insurance, after the medical deductible has been met. Prior Authorization is required.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Inpatient Hospital Services		
	20% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Medical Foods		
	20% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Medical Office Services		
Primary Physician Office Visit	$20 co-pay per visit. A deductible does not apply.	20% co-insurance, after the medical deductible has been met.
Specialist Physician Office Visit	$50 co-pay per visit. A deductible does not apply.	20% co-insurance, after the medical deductible has been met.
	Prior Authorization is required for Accidental Dental Services.	Prior Authorization is required for Accidental Dental Services and Genetic Testing BRCA.
Additional co-pays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.		
Mental Health and Substance Use Disorder Services - Inpatient		
	20% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Mental Health and Substance Use Disorder Services - Outpatient		
	Office Visits: $50 co-pay per visit. A deductible does not apply.	20% co-insurance, after the medical deductible has been met.
	All Other Outpatient Services: You pay nothing. A deductible does not apply.	20% co-insurance, after the medical deductible has been met.
		Prior Authorization is required for certain services.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Nutritional Services and Medical Nutrition Therapy		
	$20 co-pay per visit for a Primary Physician office visit or $50 co-pay per visit for a Specialist Physician office visit. A deductible does not apply.	20% co-insurance, after the medical deductible has been met.
Outpatient Hospital Services		
	Scopic Procedures: $300 per occurrence deductible per date of service for services provided at a free-standing center or in a physician's office. A deductible does not apply. 20% co-insurance, after the medical deductible has been met for services provided at an outpatient hospital-based center.	Scopic Procedures: 30% co-insurance, after the medical deductible has been met for services provided at a free-standing center or in a physician's office. 30% co-insurance, after the medical deductible has been met for services provided at an outpatient hospital-based center.
	Therapeutic Services: $300 co-pay per treatment. A deductible does not apply.	Therapeutic Services: 20% co-insurance, after the medical deductible has been met.
	All Other Services: $300 per occurrence deductible per date of service for services provided at an ambulatory surgical center or in a physician's office. A deductible does not apply. 20% co-insurance, after the medical deductible has been met for services provided at an outpatient hospital-based surgical center.	All Other Services: 30% co-insurance, after the medical deductible has been met for services provided at an ambulatory surgical center or in a physician's office. 30% co-insurance, after the medical deductible has been met for services provided at an outpatient hospital-based surgical center.
		Prior Authorization is required for Outpatient Surgery, Outpatient Therapeutic Services and Accidental Dental Services.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Outpatient Laboratory and Diagnostic Service		
	Lab, X-Ray and Minor Diagnostics Services: 20% co-insurance, after the medical deductible has been met for services provided at a free-standing lab, free-standing diagnostic center or in a physician's office. 20% co-insurance, after the medical deductible has been met for services provided at a hospital-based lab or an outpatient hospital-based diagnostic center.	Lab, X-Ray and Minor Diagnostics Services: 30% co-insurance, after the medical deductible has been met for services provided at a free-standing lab, free-standing diagnostic center or in a physician's office. 30% co-insurance, after the medical deductible has been met for services provided at a hospital-based lab or an outpatient hospital-based diagnostic center.
	CT scans, PET scans, MRI, MRA, Nuclear Medicine and Major Diagnostic Services: $300 per occurrence deductible per service for services provided at a free-standing diagnostic center or in a physician's office. A deductible does not apply. 20% co-insurance, after the medical deductible has been met for services provided at an outpatient hospital-based diagnostic center.	CT scans, PET scans, MRI, MRA, Nuclear Medicine and Major Diagnostic Services: 30% co-insurance, after the medical deductible has been met for services provided at a free-standing diagnostic center or in a physician's office. 30% co-insurance, after the medical deductible has been met for services provided at an outpatient hospital-based diagnostic center. Prior Authorization is required for CT, PET scans, MRI, MRA, Nuclear Medicine, Capsule Endoscopy and Accidental Dental Services.
Outpatient Rehabilitative Services		
Limited to: 30 visits of physical therapy. 30 visits of occupational therapy. 30 visits of speech therapy.	$20 co-pay per visit. A deductible does not apply.	20% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Pharmaceutical Products - Outpatient		
This includes medications given at a doctor's office, or in a Covered Person's home.	20% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Physician Fees for Surgical and Medical Services		
	20% co-insurance, after the medical deductible has been met.	30% 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 Out-of-Network Benefits
Pregnancy - Maternity Services		
	The amount you pay is based on where the covered health service is provided.	
		Prior Authorization is required if the stay in the hospital is longer than 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.
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, except for mammography screening.
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.		
Reconstructive Breast Surgery and Breast Prosthesis		
	The amount you pay is based on where the covered health service is provided.	
		Prior Authorization is required.
Skilled Nursing Facility Services		
Limited to 100 days per year.	20% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
		Prior Authorization is required.
Surgical Morbid Obesity Treatment		
For Network Benefits, services 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.
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.	Prior Authorization is required.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Urgent Care Center Services		
	<a>/benefitnamevalue.sql UCC_Tier1_Header_Net Error: UCC_Tier1_Header_Net Not Found. $100 co-pay per visit. A deductible does not apply. <a>/benefitnamevalue.sql UCC_Tier2_Header_Net Error: UCC_Tier2_Header_Net Not Found. <a>/benefitnamevalue.sql UCC_Tier2_Label_Net Error: UCC_Tier2_Label_Net Not Found.<a>/benefitnamevalue.sql UCC_Tier2_Net Error: UCC_Tier2_Net Not Found.	<a>/benefitnamevalue.sql UCC_NN_SM Error: UCC_NN_SM Not Found.
Additional co-pays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example, surgery and lab work.		
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.	$20 co-pay per visit. A deductible does not apply.	<a>/benefitnamevalue.sql Virtual_NN_SM Error: Virtual_NN_SM Not Found.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use 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.	$20 co-pay per visit. A deductible does not apply.	20% 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. A deductible does not apply.	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. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Eyeglass frames with a retail cost between $130 - 160.	50% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Eyeglass frames with a retail cost between $160 - 200.	50% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Eyeglass frames with a retail cost between $200 - 250.	50% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Eyeglass frames with a retail cost greater than $250.	50% co-insurance. A deductible does not apply.	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. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Low Vision Services Limited to one comprehensive low vision.	You pay nothing for Low Vision Testing. A deductible does not apply. 25% co-insurance for Low Vision Therapy. A deductible does not apply.	20% 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.

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.

Services that are not Medically Necessary.

Services performed or prescribed under the direction of a person who is not a Health Care Practitioner.

Services that are beyond the scope of practice of a Health Care Practitioner performing the service.

Services to the extent they are covered by any government unit, except for veterans in Veterans' Administration or armed forces facilities for services received for which the recipient is liable.

Services for which a Covered Person is not legally, or as a customary practice, required to pay in the absence of a health benefit plan.

The purchase, examination, or fitting of eyeglasses or contact lenses, except for aphakic patients and soft or rigid gas permeable lenses or sclera shells intended for use in the treatment of a disease or Injury. This exclusion does not apply to the Benefits provided for pediatric vision as described in the Pediatric Vision Care Services Rider.

Personal Care services and Domiciliary Care services.

Services rendered by a Health Care Practitioner who is a Covered Person's spouse, mother, father, daughter, son, brother, or sister.

Experimental Services. This exclusion does not apply to the off-label use of a Prescription Drug Product if such Prescription Drug Product is recognized for treatment in any of the standard reference compendia or in the medical literature.

Practitioner, Hospital, or clinical services related to radial keratotomy, myopic keratomileusis, and surgery which involves corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error.

In vitro fertilization, ovum transplants and gamete intrafallopian tube transfer, zygote intrafallopian transfer, or cryogenic or other preservation techniques used in these or similar procedures.

Services to reverse a voluntary sterilization procedure.

Services for sterilization or reverse sterilization for a dependent minor. This exclusion does not apply to U.S. Food and Drug Administration (FDA) approved sterilization procedures for women with reproductive capacity.

Medical or surgical treatment or regimen for reducing or controlling weight, unless otherwise specified in Section 1 of the COC.

Services incurred before the effective date of coverage for a Covered Person.

Services incurred after a Covered Person's termination of coverage, including any extension of Benefits.

Surgery or related services for Cosmetic Procedures to improve appearance, but not to restore bodily function or correct deformity resulting from disease, trauma, or Congenital or developmental Anomalies.

Services for Injuries or diseases related to a Covered Person's job to the extent the Covered Person is required to be covered by a workers' compensation law.

Services rendered from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar persons or groups.

Personal hygiene and convenience items, including, but not limited to, air conditioners, humidifiers, or physical fitness equipment.

Charges for telephone consultations, failure to keep a scheduled visit, or completion of any form.

Inpatient admissions primarily for diagnostic studies, unless authorized by us.

Except for covered ambulance services, travel, whether or not recommended by a Health Care Practitioner. This exclusion does not apply to travel for transplantation services for which Benefits are provided as described in Section 1 of the COC under Transplantation Services.

Except for Emergency Health Services, services received while the Covered Person is outside the United States.

Immunizations related to foreign travel.

Unless otherwise specified in Section 1 of the COC or in the Pediatric Dental Services Rider, dental work or treatment which includes hospital or professional care in connection with:

- The operation or treatment for the fitting or wearing of dentures
- Orthodontic care or malocclusion

- Operations on or for treatment of or to the teeth or supporting tissues of the teeth, except for removal of tumors and cysts or treatment of injury to natural teeth due to an accident if the treatment is received within 6 months of the accident; and
- Dental implants.

Accidents occurring while and as a result of chewing. This exclusion does not apply to the Benefits provided for pediatric dental services as described in the Pediatric Dental Services Rider.

Routine foot care, including the paring or removing of corns and calluses, or trimming of nails, unless these services are determined to be Medically Necessary.

Arch support, orthotic devices, in-shoe supports, orthopedic shoes, elastic supports, or exams for their prescription or fitting, unless these services are determined to be Medically Necessary.

Inpatient admissions primarily for physical therapy, unless authorized by us.

Treatment leading to or in connection with transsexualism, or sex changes or modifications, including but not limited to surgery.

Treatment of sexual dysfunction not related to organic disease.

Services that duplicate benefits provided under federal, State, or local laws, regulations, or programs.

Nonhuman organs and their implantation.

Nonreplacement fees for blood and blood products.

Lifestyle improvements, including nutrition counseling, or physical fitness programs, unless included as a Covered Service.

Wigs or cranial prosthesis.

Weekend admission charges, except for emergencies and maternity, unless authorized by us.

Outpatient orthomolecular therapy, including nutrients, vitamins, and food supplements.

Temporomandibular joint syndrome (TMJ) treatment and treatment for craniomandibular pain syndrome (CPS), except for surgical services for TMJ and CPS, if Medically Necessary and if there is a clearly demonstrable radiographic evidence of joint abnormality due to disease or Injury.

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.

Services for conditions that State or local laws, regulations, ordinances, or similar provisions require to be provided in a public institution.

Services for, or related to, the removal of an organ from a covered person for purposes of transplantation into another person, unless the: Transplant recipient is covered under the plan and is undergoing a covered transplant, and Services are not payable by another carrier.

Physical examinations required for obtaining or continuing employment, insurance, or government licensing.

Nonmedical ancillary services such as vocational rehabilitation, employment counseling, or educational therapy.

Private hospital room, unless authorized by us.

Private Duty Nursing, unless authorized by us.

Treatment for Mental Health or Substance Use Disorder Services for the following:

- Services by pastoral or marital counselors.
- Therapy for sexual problems.
- Treatment for learning disabilities or intellectual disabilities.
- Telephone therapy.
- Travel time to the Covered Person's home to conduct therapy.
- Services rendered or billed by a school, or halfway houses or members of their staff.
- Marriage counseling.
- Services that are not Medically Necessary.

Cardiac rehabilitation therapy and pulmonary rehabilitation therapy services provided at a place of service that is not equipped and approved to provide such therapies.

Cardiac rehabilitation therapy and pulmonary rehabilitation therapy provided as maintenance programs. Maintenance

programs consist of activities that preserve the individual's present level of function and prevent regression of that function. Maintenance begins when therapeutic goals of a treatment plan have been achieved, or when no additional progress is apparent or expected to occur.

Payment of any claim, bill, or other demand or request for payment for health care services that the appropriate regulatory board determines were provided as a result of a prohibited referral. "Prohibited referral" means a referral prohibited by 1-302 of the Maryland Health Occupations Article.

For Benefits other than prescription contraceptive coverage, we will grant a request for an exclusion from a Benefit under this Policy for an Enrolling Group, that is a bona fide religious organization, and such Benefit is in conflict with the Enrolling Group's religious beliefs and practices.

For prescription contraceptive coverage, we will grant a request for exclusion of contraceptive prescription drug products under the Policy for an Enrolling Group that meets the requirements of a religious employer as defined under 45 CFR §147.131 or for an Enrolling Group that meets the definition of an eligible organization as defined under 45 CFR §147.131. Such eligible organization must maintain a self-certification.

Services your plan does not cover (Exclusions)

Pediatric Dental 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. This exclusion does not apply to preventive, diagnostic, or orthodontic Dental Services.

Any Dental Procedure not performed in a dental setting.

Procedures that are considered to be Experimental Services. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental 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 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. This exclusion does not apply to the following when such Benefits are not provided under your medical coverage: Radical Excision - Lesion Diameter up to 1.25 cm; Excision of Malignant Tumor- Lesion Diameter up to 1.25 cm; Removal of Odontogenic Cyst or Tumor- Lesion Diameter up to 1.25 cm; Removal of Odontogenic Cyst or Tumor- Lesion Diameter greater than 1.25 cm; Removal of Non-odontogenic Cyst or Tumor- Lesion Diameter up to 1.25 cm; and Removal of Non-odontogenic Cyst or Tumor- Lesion Diameter greater than 1.25 cm.

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.

Upper and lower jaw bone surgery. Orthognathic surgery and jaw alignment. This exclusion does not apply to Benefits provided for services related to temporomandibular joint disorder.

Charges for failure to keep a scheduled appointment without giving the dental office 24 hour notice.

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. This exclusion does not apply to Benefits provided as described above under Benefits after Coverage Termination for Dental Services in the Pediatric Dental Rider.

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.

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.

Payment of any claim, bill, or other demand or request for payment for health care services that the appropriate regulatory board determines were provided as a result of a prohibited referral. "Prohibited referral" means a referral prohibited by 1-302 of the Maryland Health Occupations Article.

Pediatric Vision 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 Certificate.

Non-prescription items (e.g. Plano lenses).

Replacement or repair of lenses and/or frames that have been lost or stolen.

Optional Lens Extras not listed in Vision Care Services.

Missed appointment charges.

Applicable sales tax charged on Vision Care Services.

Payment of any claim, bill, or other demand or request for payment for health care services that the appropriate regulatory board determines were provided as a result of a prohibited referral. "Prohibited referral" means a referral prohibited by 1-302 of the Maryland Health Occupations Article.

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