SECTION 3 -EXCLUSIONS AND LIMITATIONS

3.1 PREEXISTING CONDITIONS

We do not cover services or supplies related to the treatment of a Preexisting Condition until the date that the Member has been covered under this Policy for at least twelve (12) consecutive months.

3.2 SERVICES NOT MEDICALLY NECESSARY AND NOT COVERED

We do not cover any medical service, Prescription Drug, medicine, equipment, supply or procedure that is not Medically Necessary. We do not cover a service that is not a Covered Service. Additionally, Health Care Services determined to be provided as a result of a referral prohibited by law are excluded.

3.3 NON-EMERGENCY SERVICES

We do not cover Non-Emergency Services that are provided in an emergency facility. Emergency Services are described in Section 2.18.

3.4 NON-AUTHORIZED SERVICES

We do not cover any services, Hospital, professional or otherwise, that are not authorized and approved in advance by Us, when we require pre-authorization for such services. See Section 4.2 for information concerning pre-authorization. This exclusion does not apply to Emergency Services or Urgent Care.

3.5 PERSONAL OR CONVENIENCE ITEMS

We do not cover personal or convenience items. Some examples of such items are

- special diets,
- in-Hospital television or telephone,
- private room unless Medically Necessary, and
- housekeeping, homemaker services, and room and board as part of home health services.

3.6 AMBULANCE SERVICE

We do not cover ambulance services for non-Emergency Services, except as described in Section 2.19. Benefits for transportation by air ambulance are paid at the cost of ground ambulance transportation, less any Copayment.

3.7 EYEGLASSES AND CORRECTIVE LENSES

We do not cover eyeglasses and corrective lenses. However, We do cover the first pair of corrective lenses needed after cataract surgery.

3.8 NO LEGAL OBLIGATION TO PAY

We do not cover:

- services that are paid for or furnished by the United States Government or one of its agencies or other laws (except as required under Medicaid program or other applicable Federal Law);
- services and supplies furnished under or as part of a study, grant, or research program (except those services received during a Medical Clinical Trial described in Section 2.21); and
- services for which a Member has reduced or no financial liability or that would be provided at a reduced charge or no charge in the absence of insurance.

3.9 CUSTODIAL CARE

Custodial Care includes but is not limited to, private duty nursing, nursing home care, rest cures and domiciliary care, along with all related services. Care is considered custodial when it is primarily for meeting personal needs. For example, custodial care includes help in:

- walking,
- getting in and out of bed,
- bathing,
- dressing,
- shopping,
- eating and preparing meals,
- performing general household services,
- taking medicine, or
- furnishing other home services mainly to help people in meeting personal, family or domestic needs to include extraordinary personal needs created by the Illness of a Family Dependent.

Custodial care is excluded regardless of the location or setting. All services provided to persons confined to long-term care facilities and boarding homes is excluded, unless such service does not constitute Custodial Care and is Medically Necessary. Care for long-term patients who are ventilator dependent is also excluded, unless such care does not constitute Custodial Care and is Medically Necessary.

3.10 BLOOD

We do not cover whole blood, if replaced.

3.11 EXAMINATIONS

We do not cover physical examinations for

- employment,
- travel,
- school,

- camp,
- sports,
- licensing,
- insurance,
- adoption,
- marriage, or
- other examinations ordered by a third party.

We do not cover eye examinations for refractive correction.

3.12 COSMETIC SERVICES AND SURGERY

We do not cover health services and associated expenses for cosmetic procedures. Cosmetic procedures are those procedures that improve physical appearance. Examples of services for cosmetic procedures are:

- pharmacological regiments,
- nutritional procedures or treatment,
- plastic surgery,
- salabrasion,
- chemosurgery and other skin abrasion procedures associated with the removal of scars,
- tattoos,
- actinic changes which are performed as a treatment for acne,
- radial keratotomy and other refractive eye surgery,
- replacement of an existing breast implant if the earlier breast implant was for cosmetic purposes, unless the removal is Medically Necessary.

The following are covered:

- reconstruction of the breast on which a mastectomy has been performed,
- surgery and reconstruction of the non-affected breast to achieve symmetry, and
- other services required by the Women's Health and Cancer Rights Act of 1998, such as breast prosthesis and treatment of complications.

3.13 DENTAL AND ORAL SURGICAL SERVICES

Unless otherwise specified in Sections 2.2.3. or 2.23, the following dental services are not covered:

- crowns,
- bridges,
- dentures,
- other intraoral dental prosthetic devices,
- dental restorative care,
- periodontal care,
- treatment of impacted wisdom teeth,
- orthodontics,
- orthognathic surgery,

- Hospital and professional services and supplies associated with the above services, and
- preventive dental services unless the procedure is needed to treat a condition caused by a congenital deformity, disease or Injury.

3.14 EXPERIMENTAL AND INVESTIGATIVE PROCEDURES OR TREATMENTS

Except for health services in a Medical Clinical Trial (described in Section 2.21), We do not cover experimental and investigative procedures or treatments such as

- any treatment, procedure, facility, equipment, device, or supply not accepted as standard medical treatment for the condition being treated; or
- any item or technology requiring federal or other government agency approval not granted at the time services are rendered.

The Medical Director determines whether a procedure or treatment is experimental or investigative. Drugs will not be excluded if coverage for an off-label use of the drug is

- recognized for the treatment in any of the standard reference compendia or in the medical literature, or
- approved by the FDA.

3.15 TRANSPLANTS

We do not cover organ transplants, except those listed under Section 2.27 of this Policy. We do not cover the cost of any care, including medical and surgical complications resulting from non-covered transplants or the cost of any care arising from an organ donation by a Member when the recipient is not a Member.

3.16 MATERNITY AND FAMILY PLANNING

3.16.1 We do not cover any medical service, Prescription Drug, medicine, supply or procedure related to the following:

- reversal of voluntarily sterilization,
- sex change, and
- home delivery for childbirth;

3.16.2 We do not cover any pregnancy related services (including all pre- and post-natal care) and including any Health Care Provider's services for any labor and delivery or other pregnancy-related services, except for inpatient Hospital care as provided for in Section 2.4, and In Vitro Fertilization benefits as provided for in Section 2.9.

3.17 PROSTHETIC DEVICES, DISPOSABLE ITEMS, AND DURABLE MEDICAL EQUIPMENT

We do not cover:

- over-the-counter devices and/or supplies (such as ACE wraps, elastic supports, finger splints and soft cervical collars);

- dental prosthesis, bionics, special shoes, sunglasses, corsets, clothing, disposable items, air mattresses, breast pumps, orthodontic braces, penile prostheses, orthotics, needles and syringes, and all other devices that are not Medically Necessary;
- hearing aids and hearing related implants, including cochlear implants, unless specified otherwise in Section 2.16;
- replacement and repair of prosthetic devices unless the Medical Director determines it is Medically Necessary and the need for such replacement or repair was not as a result of a person's misuse or abuse of the prosthetic devices;
- durable medical equipment that does not serve a medical purpose or cannot be used in a Member's home; and
- purchase or rental of supplies of common household use such as exercise cycles, air purifiers, central or unit air conditioners, water purifiers, allergenic pillows or mattresses, and waterbeds.

We cover:

- diabetes equipment, supplies and self management training; and
- orthodontics associated with cleft lip and/or cleft palate.

3.18 RADIAL KERATOTOMY, EYE EXERCISES, AND VISION CARE SERVICES

We do not cover the following eye care:

- radial keratotomy,
- surgeries to correct myopia,
- eye exercises, and
- vision care services.

3.19 THERAPIES

The number of visits for therapies is limited as stated on the Member's Schedule of Benefits. This limit does not apply to habilitative services as provided for in Section 2.8.2.

3.20 HOSPICE

We do not cover the following Hospice services:

- health care, visits, medical equipment or supplies that are not included in the Physician's recommended plan of treatment;
- financial and legal counseling; and
- any service for which the Hospice does not customarily charge the Member, or his or her family.

3.21 SURGICAL AND OTHER TREATMENT FOR OBESITY

We do not cover services related to the treatment of obesity or weight reduction, such as

- Inpatient Hospital services,
- surgical procedures, for example
  - intestinal bypass surgery,
  - stomach stapling,
  - balloon dilation, or
  - wiring of the jaw;
- diet programs, such as Optifast or Nutri-System, as well as any tests, examinations or services related to diet programs, and
- procedures or programs of similar nature, as well as the complications of such procedure or program.

Exceptions to this exclusion are Services described in Section 2.24, Treatment of Morbid Obesity.

3.22 ROUTINE FOOT CARE

We do not cover routine foot care unless it is Medically Necessary. Examples of routine foot care are the removal or reduction of corns and calluses, clipping of the nails, treatment of flat feet, fallen arches, and chronic foot strain.

3.23 FOOD OR FOOD SUPPLEMENTS

We do not cover the following:

- Food or food supplements, unless Your Physician prescribes Medical Foods and Low Protein Modified Food Products for the treatment of Inherited Metabolic Diseases as described in Section 2.1.14.
- Nutritional counseling unless Medically Necessary and approved by Us.

3.24 GENETIC COUNSELING

Genetic counseling and genetic studies that are not needed for diagnosis or treatment of genetic abnormalities are excluded.

3.25 TRAVEL

We do not cover travel other than ambulance travel for Emergency Services, even when a Provider prescribes it.

3.26 IMMUNIZATIONS

Immunizations for travel or employment are not covered.

3.27 MILITARY SERVICE

We do not cover care for military service-connected conditions or disabilities to which the Member is legally entitled and for which facilities are available.

3.28 WAR OR ACT OF WAR

We do not cover services resulting from war or act of war.

3.29 APPOINTMENTS

We do not cover charges a Member has to pay because he or she did not keep or cancelled an appointment.

3.30 AUDIOMETRIC SERVICES

We do not cover audiometric testing and expenses for hearing aids except as provided in Section 2.16. This exclusion does not apply to hearing screening for newborns and screening in connection with cleft lip and/or cleft palate.

3.31 SUICIDE AND/OR SELF-INFLICTED INJURY

We do not cover suicide or intentional self-inflicted Injury or any self inflicted injury while the Member is insane.

3.32 GROWTH HORMONE

Growth hormone for idiopathic short stature or that is not Medically Necessary, as determined by Us is excluded.

3.33 BREAST REDUCTION

Breast reduction is excluded.

3.34 VARICOSE VEIN SURGERY

Varicose vein surgery is excluded

3.35 BLEPHAROPLASTY (EYELID REPAIR)

Blepharoplasty (eyelid repair), is excluded.

3.36 PROHIBITED REFERRAL

Payment of any claim, bill, or other demand or request for payment for Health Care Services that the appropriate regulatory board determines was provided because of a prohibited referral is excluded.