

2010 COVERED SERVICES FOR THE CENTURYLINK PPO & CDHP

Abortion

Abortion is only covered if the life of the mother would be endangered by medical complications arising from the pregnancy, or in case of incest or rape.

Acupuncture

Acupuncture services for pain therapy provided that:

- Another method of pain management has failed; and
- The service is performed by a licensed provider in the provider's office.

Covered health services include treatment of nausea as a result of chemotherapy, early pregnancy and post-operative procedures.

Any combination of network and non-network benefits is limited to 20 visits per calendar year.

Allergy and Other Injections

Ambulance Service

Professionally licensed ambulance charges are covered if illness or injury requiring the ambulance is a medical emergency. Emergency transfer between facilities is covered at 100%. Emergency transportation by air ambulance is covered for the first trip to the nearest hospital qualified for treatment of the injury or sickness. Use of an ambulance in a non-emergency situation is not covered.

Anesthetics and Oxygen

Anesthesiologist Services

Annual Physical Exam

See Preventive Care.

Antigens

Artificial Disc Replacement Surgery

Pre-certification is required through Healthcare Management Services (HMS). Includes lumbar and cervical; levels 1 and 2.

Birth Control Services

Covered services include charges such as fitting of a diaphragm, insertion or removal of an IUD, voluntary sterilization and Depo Provera.

Blood/Plasma

Coverage includes preservation of autologous blood products for scheduled surgery for up to eight weeks only if not donated or replaced.

Blood Transfusions

Cardiac Rehabilitation

Chemotherapy

Chiropractic Services

Benefits for spinal treatment include chiropractic and osteopathic manipulative therapy. Benefits include diagnosis and related services and are limited to one visit and treatment per day.

Please note that the Plan excludes any type of therapy, service or supply including, but not limited to spinal manipulations by a chiropractor or other doctor for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring. Any combination of network and non-network benefits for spinal treatment is limited to 20 visits per calendar year.

Cochlear Implants

Congenital Heart Disease

The plan pays benefits for Congenital Heart Disease (CHD) services ordered by a physician and received at a CHD Resource Services program. Benefits are available for the following CHD services:

- Outpatient diagnostic testing;
- Evaluation;
- Surgical interventions
- Interventional cardiac catheterizations (insertion of a tubular device in the heart);
- Fetal echocardiograms (examination, measurement and diagnosis of the heart using ultrasound technology); and
- Approved fetal interventions.

CHD services other than those listed above are excluded from coverage, unless determined by the Plan Administrator to be proven procedures for the involved diagnoses.

If you receive Congenital Heart Disease services from a facility that is not a Designated Facility, the plan pays benefits as described under:

- Physician's Office Visits;
- Physician Fees for Surgical and Medical Services;
- Scopic Procedures – Outpatient Diagnostic and Therapeutic;
- Therapeutic Treatments – Outpatient;
- Hospital – Inpatient Stay; and
- Surgery – Outpatient.

Please remember that the Plan Administrator must be notified as soon as CHD is suspected or diagnosed.

Note: The services described under *Travel and Lodging* are covered health services only in connection with CHD services received at a Congenital Heart Disease Resource Services program.

Cosmetic Surgery

Charges are covered for treatment of accidental bodily injury occurring while covered and received within 12 months of the accidental bodily injury, for correction of a congenital anomaly in a covered child, or in connection with a mastectomy.

Dental Care

Prior notification is required through Personal Health Support. If you do not notify Personal Health Support, the non-notification penalty of \$150 will apply. Dental services are covered when the following are true:

- Treatment is necessary because of accidental damage.
- Dental services are received from a Doctor of Dental Surgery, "D.D.S." or Doctor of Medical Dentistry, "D.M.D."
- The dental damage is severe enough that initial contact with a physician or dentist occurred within 72 hours of the accident.

Benefits are available only for treatment of a sound, natural tooth. The Physician or dentist must certify that the injured tooth was:

- A virgin or unrestored tooth, or
- A tooth that has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant and functions normally in chewing and speech.

Dental services for final treatment to repair the damage must be both of the following:

- Started within three months of the accident.
- Completed within 12 months of the accident.

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered an "accident". Benefits are not available for repairs to teeth that are injured as a result of such activities.

Dental sedation and general anesthesia is covered when medically necessary.

Diagnostic Tests

Dialysis

Drug and/or Alcohol Program

Durable Medical Equipment and Supplies

Prior notification is required through Personal Health Support before obtaining any single item of durable medical equipment that costs more than \$1,000 (either purchase price or cumulative rental of a single item). If you do not notify Personal Health Support, the non-notification penalty of \$150 will apply.

Durable medical equipment is covered that meets each of the following criteria:

- Ordered or provided by a physician for outpatient use.
- Used for medical purposes.
- Not consumable or disposable.
- Not of use to a person in the absence of a disease or disability.

If more than one piece of durable medical equipment can meet your functional needs, benefits are available only for the most cost-effective piece of equipment. Cost effective means the least expensive equipment that performs the necessary function.

Examples of durable medical equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard hospital-type bed.
- Oxygen concentrator units and the rental of equipment to administer oxygen.
- Delivery pumps for tube feedings.
- Braces that stabilize an injured body part are considered durable medical equipment and are a covered health service, including necessary adjustments to shoes to accommodate braces.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure or conditions.
- Shoe orthotics that are prescribed by a physician are covered up to a calendar year maximum of \$350.

Benefits are available for a single unit of durable medical equipment (example one insulin pump) and provide repair for that unit.

Benefits are provided for the replacement of a type of durable medical equipment once every three calendar years.

Personal Health Support will decide if the equipment should be purchased or rented. You must purchase or rent the durable medical equipment from the vendor Personal Health Support identifies.

Emergency Care

Emergency care is covered for life-threatening medical conditions 24 hours a day, seven days a week, no matter where you are. A life-threatening condition is any illness or condition which, if not treated immediately, might result in death or serious harm to bodily function.

In case of a life-threatening condition, go immediately to the nearest hospital emergency room. Your ID Card will provide information for the hospital that you have medical coverage.

If you are admitted to the hospital following an emergency visit, you, the attending physician, the hospital, or a family member must inform the Plan Administrator within 48 hours or on the first working day following admission or you will pay a \$150 penalty. The penalty does not apply to the out-of-pocket maximum.

Enteral Nutrition

Enteral nutrition is covered if it is the sole source of nutrition and is specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU).

Growth Hormone Therapy

Benefit is limited to dwarfism secondary to pituitary gland failure.

Hearing Care Examinations

Benefit is limited to a maximum of \$100 per year.

Hearing Aids

Benefit is limited to a maximum of \$1,000 per ear device every three years. Member must see an Audiologist in order to be eligible for this benefit.

Home Health Care

Prior notification is required through Personal Health Support. If you do not notify Personal Health Support, the non-notification penalty of \$150 will apply. A maximum of 120 home health care visits during a calendar year shall be covered. One visit is equal to four hours of skilled care services. Covered health expenses include care furnished to an individual in the home, provided the following conditions are met:

- The participant is confined to the home other than for occasional trips to obtain medical care; and
- The care is rendered by or through a home health care agency which meets Medicare requirements and is licensed by the state(s) in which it operates as a home health care provider.

Home health care expenses are not included as covered health services if they are incurred in connection with any of the following:

- Services of a person who ordinarily resides in your home, or is a member of your family or the family of your spouse;
- Services of any social worker;
- Transportation services.

Hospice Care

Prior notification is required through Personal Health Support. If you do not notify Personal Health Support, the non-notification penalty of \$150 will apply. Hospice programs provide a terminally ill patient, with a life expectancy of six months or less, with care in surroundings that are as comfortable and dignified as possible.

The Plan will pay a lifetime maximum of \$10,000 for approved treatment, including supportive care for both the patient and the family. A written plan of care established by a physician and a hospice care agency is required.

A hospice care agency is defined as a full-time licensed or certified agency or organization which provides skilled medical and social services, and psychological and dietary counseling. In order to qualify, the agency must also provide doctor services, physical and occupational therapy, home health aide services, and inpatient care when needed to control pain and other medical symptoms, and it must develop a program of care for each of its patients.

Covered charges for hospice care include charges made by a hospice facility, hospital, or convalescent facility for the following services and supplies, if part of the approved program:

- Room and board (based on the facility's most common semi-private room rate) and other services and supplies provided on an inpatient basis to control pain and other medical symptoms.
- Medically appropriate nursing care by a graduate registered nurse or a licensed practical nurse for up to 8 hours in any one day.
- Medical social services under the direction of a physician, including:
 - Assessment of the patient's social, and emotional needs;
 - Assistance in identifying and obtaining community resources;
 - Psychological and dietary counseling;
 - Bereavement counseling;
 - Respite care furnished during a period of time when the patient's family or usual caretaker is not attending the patient's needs.

Hospice care benefits are not payable toward funeral arrangements, financial counseling, legal counseling, estate planning, or the drafting of a will. Caretaker services that are not covered include sitter or companion services, transportation, housecleaning, and maintenance of the house.

Hospital Services

Prior notification is required through Personal Health Support. If you do not notify Personal Health Support, the non-notification penalty of \$150 will apply. Semi-private room, board, and other services while confined to a hospital, including charges for medications and intensive care are covered.

Immunizations

See Preventive Care.

Infertility Treatment

The Plan pays benefits for infertility services and associated expenses including:

- Diagnosis and treatment of an underlying medical condition that causes infertility, when under the direction of a physician;
- Drug therapy;
- In vitro fertilization (IVF), gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT);

- Artificial insemination;
- Embryo transport; and
- Donor ovum and semen and related costs, including collection, preparation and storage of.

Services are covered at normal plan benefits up to a calendar year maximum of \$1,000 (deductibles and out-of-network co-insurance apply in all medical plan options). Maximum lifetime reimbursement is \$3,000.

Inoculations

See "Preventive Care" elsewhere in this summary of covered services.

Laboratory Services

Mammogram Screening

If screening is preventive, see Preventive Care.

Maternity Care

Prior notification for maternity care that exceeds 48 hours for normal delivery and 96 hours for Cesarean birth is required through Personal Health Support. If you do not notify Personal Health Support, the non-notification penalty of \$150 will apply.

Direct or indirect expenses incurred for a dependent child's pregnancy are not covered.

Delivery services may be incurred in a hospital or a birthing center and may include charges for services of a licensed or certified midwife acting within the scope of that license or certification or a licensed registered graduate nurse who assists women with childbirth. A "birthing center" is a facility licensed by the state in which it operates to provide maternity and obstetrical medical care for normal delivery, cesarean section, and miscarriage, and which contracts with a hospital for the provision of emergency medical care for complications of childbirth.

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under Federal Law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. These are federally mandated requirements under the Newborns' and Mothers' Health Protection Act of 1996 which apply to this plan. The hospital or other provider is not required to get authorization for the time periods stated above. Authorizations are required for longer lengths of stay. If the mother agrees, the attending physician may discharge the mother and/or the newborn child earlier than these minimum timeframes.

Mental Health Services

Naturopathic Professional Services

Any combination of network and non-network benefits for naturopathic services are limited to 20 visits per calendar year.

Materials such as herbs and nutritional supplements, are generally not covered by the Plan.

Newborn Care

A newborn must be added as an eligible dependent within 90 days of the birth to receive coverage.

Nutritional Counseling

Covered services include those provided by a registered dietician in an individual session for covered persons with medical conditions that require a special diet. Some examples of such medical conditions include:

- Diabetes mellitus
- Coronary artery disease
- Congestive heart failure
- Severe obstructive airway disease
- Gout
- Renal failure
- Phenylketonuria
- Hyperlipidemias

Benefits are limited to three individual sessions during a covered person's lifetime for each medical condition.

Obesity Surgery

Personal Health Support approval required for surgical treatment of morbid obesity received on an inpatient basis in an approved facility. All of the following criteria must be met:

- Covered Person must have a minimum BMI of 40 or BMI equal to or greater than 35 with co-morbid conditions;
- Covered Person must have documentation of a diagnosis of morbid obesity for a minimum of five (5) years from a Physician;
- Covered Person must be age 18 or older

Surgery must be performed at a United Healthcare Bariatric Centers of Excellence facility or Highmark Blue Distinction Centers.

Limited to one surgery per lifetime.

Oral Surgery

Coverage for outpatient facility and anesthesia services (not covered by the Dental Plan) are subject to eligible expense rules under medical plans (i.e., anesthesia for oral surgery). See your Dental Summary Plan Description for oral surgery coverage.

Organ Tissue Transplant Program

See Transplant Program.

Orthognathic Surgery

Surgery is covered in the following situations:

- A jaw deformity resulting from facial trauma or cancer; or
- A skeletal anomaly of either the maxilla or mandible, that demonstrates a functional medical impairment such as one of the following:
 - Inability to incise solid foods
 - Choking on incompletely masticated solid foods
 - Damage to soft tissue during mastication
 - Speech impediment determined to be due to the jaw deformity
 - Malnutrition and weight loss due to inadequate intake secondary to the jaw deformity.

Orthotics

See Durable Medical Equipment.

Pap Smear

If care is preventive, see Preventive Care.

Physical/Occupational Therapy

See Rehabilitation Services.

Physician Services

A physician is any person who is legally licensed and within the scope of their license qualified to practice medicine, psychology, osteopathy, dentistry, podiatry or naturopathy medicine. The term physician **does not** include Christian Science practitioners.

An office visit is considered to be each separate patient/physician encounter when a patient receives care from several physicians on the same or subsequent days.

Pre-Admission (hospital) Testing

Prescription Drugs

Covered prescription drugs are limited to those which are prescribed by a physician to treat an illness or injury which is covered by the Plan. It does not include drugs that may be prescribed, but are also available without prescription.

Preventive Care

100% for services included on the preventive schedule. Exam charges for a visit which includes a diagnosis or symptom(s) will be covered at normal plan benefits.

Private Duty Nursing Services by a Registered or Licensed Nurse

Prior notification is required through Personal Health Support. If you do not notify Personal Health Support, the non-notification penalty of \$150 will apply. Care must be ordered by a physician, outside of hospital and must not be custodial in nature to be covered.

Prosthetic Devices

See Durable Medical Equipment.

Radiation Therapy

Covered charges include x-ray, radium cobalt, telecobalt, telecoasium and radioisotope therapy.

Reconstructive Health Services

Prior notification is required through Personal Health Support. If you do not notify Personal Health Support, the non-notification penalty of \$150 will apply.

Reconstructive procedures are services performed when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function for an organ or body part.

Improving or restoring physiologic function means that the organ or body part is made to work better. An example of a reconstructive procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.

Benefits for reconstructive procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Replacement of an existing breast implant is covered by the plan if the initial breast implant followed a mastectomy.

There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. A good example is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a reconstructive procedure. In other cases, improvement in appearance is the primary intended purpose, which is considered a cosmetic procedure. This plan does not provide benefits for cosmetic procedures.

Rehabilitative Services – Outpatient Therapy

Short-term outpatient rehabilitation services are available for: physical therapy, occupational therapy, speech therapy, pulmonary rehabilitation therapy, and cardiac rehabilitation therapy.

Rehabilitation services must be performed by a licensed therapy provider, under the direction of a physician. Benefits are available only for rehabilitation services that are expected to result in significant physical improvement in your condition. Benefits cease when progress is no longer being made or the previous level of function has been restored. The Plan Administrator has the right to deny benefits if treatment ceases to be therapeutic and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or recurring. Please note that benefits for speech therapy only apply when the speech impediment or speech dysfunction results from injury, stroke, surgery, radiation therapy or other treatment which affects the vocal cords or a congenital anomaly. A congenital anomaly is a physical developmental defect that is present at birth, and is generally identified within the first twelve months of birth.

Respiratory/Inhalation Therapy

Routine Annual Physical Examination

See Preventive Care.

Second Surgical Opinion

Covered at 100% for up to two (i.e., a second opinion and third opinion).

Skilled Nursing/Convalescent Facility

Prior notification is required through Personal Health Support. If you do not notify Personal Health Support, the non-notification penalty of \$150 will apply. A skilled nursing facility means a facility licensed to provide room and board and skilled nursing services for persons recovering from an illness/injury. The facility shall provide 24-hour skilled nursing service under the supervision of a graduate registered nurse or physician and maintain a daily medical record.

The term skilled nursing facility does not include nursing homes, or an institution which is principally a place of rest, for the aged, for custodial or educational care, or for the treatment of mental illness or substance abuse. Covered health services are subject to the following limitations:

- The program of medical care must be pursuant to a plan of treatment written by the attending physician, and filed with and approved by the Plan Administrator in advance.
- The patient must be admitted to the skilled nursing facility in lieu of hospital admission, or continued confinement.
- The level of medical care under the program must not be available in a less comprehensive setting, such as the patient's home or on an outpatient basis.
- The attending physician shall visit the patient at least once each week while in the skilled nursing facility.

Covered health services for room and board in a private room shall be limited to the skilled nursing facility's average semi-private room rate. If the facility does not have semi-private rooms, covered health services for room and board shall be limited to the average semi-private room rate at skilled nursing facilities in the local area.

The annual maximum benefit is limited to 120 days.

Speech Therapy

Speech therapy must be given to restore speech lost or impaired due to one of the following:

- Congenital abnormality
- Surgery, radiation therapy or other treatment which affects the vocal cords.
- Cerebral thrombosis (cerebral vascular accident)
- Accidental injury that happens while covered under the plan.

Sterilization

Covered services include vasectomy and tubal ligation.

Substance Abuse Treatment

Surgery - Inpatient and Outpatient

Prior notification is required through Personal Health Support. If you do not notify Personal Health Support, the \$150 non-notification penalty will apply. Although not required, it is advisable to seek a second opinion for surgery to confirm availability of coverage.

Temporal Mandibular Joint Syndrome (TMJ)

Covered services include surgery of the jaw and realignment as related to the correction of TMJ. For non-surgical charges, including physical therapy of the jaw, see your Dental Summary Plan Description.

Transplant of Tissues and Organs

Inpatient facility services (including evaluation for transplant, organ procurement and donor searches) for transplantation procedures must be ordered by a Network Provider. Benefits are available to the donor and the recipient when the recipient is covered under this plan. The transplant must meet the definition of a Covered Health Service and cannot be experimental or investigational or unproven. Examples of transplants for which benefits are available include, but are not limited to:

- heart;
- heart/lung;
- lung;
- kidney;
- kidney/pancreas;
- liver;
- liver/kidney;
- liver/intestinal;
- pancreas;
- intestinal; and
- bone marrow (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service – please see below.

Benefits are also available for cornea transplants that are provided by a Network Provider at a network Hospital. You are not required to notify the Plan Administrator of a cornea transplant nor is the cornea transplant required to be performed at a Designated United Resource Networks Facility.

The search for bone marrow/stem cells from a donor who is not biologically related to the patient is a Covered Health Service. If a separate charge is made for a bone marrow/stem cell search, the Plan will pay up to \$25,000 for all charges made in connection with the search.

The Plan has specific guidelines regarding Benefits for transplant services.

Travel and lodging expenses may be available.

Urgent Care

Urgent conditions are injuries or illnesses that require care either the same day or the next, but they are not medical emergencies. They include minor sprains and injuries, simple burns and wounds, flare-ups of chronic conditions, complaints and minor infectious illnesses.

Vision Care

Medical or surgical treatment of the eye. For non-medical care, see your Vision Summary Plan Description.

Well Child Care

100% for services included on the preventive schedule.

Wigs

One wig is covered after chemotherapy treatment.

X-ray Services

HEALTH SERVICES NOT COVERED

This section is a summary of services not covered by the medical plan. It is not meant to be an exhaustive list of services not covered.

It is your responsibility to confirm the availability of coverage by calling the Plan Administrator before services are received.

The following are exclusions that apply to the health care plans:

- Experimental or investigational or unproven services. Medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time the Plan Administrator makes a determination regarding coverage in a particular case is determined to be:
 - (a) not approved by the U.S. Food and Drug Administration (“FDA”) to be lawfully marketed for the proposed use and not identified in the American Hospital formulary Service, or the United States Pharmacopoeia Dispensing Information, as appropriate for the proposed use; or
 - (b) subject to review and approval by any institutional review board for the proposed use; or
 - (c) the subject of an ongoing clinical trial that meets the definition of a Phase, 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or
 - (d) not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

The Plan Administrator, in its judgment, may deem an experimental, investigational or unproven service to be covered under this Plan for treating a life threatening sickness or condition if it is determined by the Plan Administrator to be: proven safe with promising efficacy, and is provided in a clinically controlled research setting, and uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Note: *For the purpose of this definition, the term “life threatening” is used to describe sicknesses or conditions that are more likely than not to cause death within one year of the date of the request for treatment.*

- Any treatment, service or supply that is not a covered health service. This includes services that are not generally accepted in medical practice as necessary for the prevention, diagnosis or treatment of illness or injury, charges for any unnecessary repetition of tests, cosmetic surgery, orthognathic (poor bite, over bite, under bite) except as stated under Covered Medical Services, malegynecomastia, orthotics, eye surgery including laser and other surgery that is intended to allow you to see better.

- Expenses in excess of eligible expenses.
- Any treatment, service or supply furnished on an inpatient basis if the patient's condition could have been safely and adequately diagnosed and/or treated on an outpatient basis.
- Maintenance care which is defined as any treatment, service or supply furnished primarily to a) maintain rather than improve a level of physical or mental function, or b) provide a protected environment free from exposures that can worsen the patient's physical or mental condition.
- Any counseling service, i.e., marriage, family, child, career, social adjustment, pastoral or financial, unless covered under the managed mental health program and approved in advance.
- Health care services that a school system is required to provide under any law.
- Personal comfort, hygiene or convenience items such as a television, telephone, private room except when medically appropriate, housekeeping, homemaker, or meal services as part of home health care, and modifications and alterations in homes or places of residence, including equipment to accommodate physical handicaps or disabilities.
- Custodial care services that do not require special skills or training and that:
 - Provide assistance in activities of daily living (including, but not limited to: feeding, dressing, bathing, ostomy care, incontinence care, checking of routine vital signs, transferring and ambulating);
 - Do not seek to cure or which are provided during periods when the medical condition of the patient who requires the service is not changing; or
 - Do not require continued administration by trained medical personnel in order to be delivered safely and effectively.
- Charges for any claim received by the Claims Administrator more than 12 months from the date of service.
- Institutional care that is for the primary purpose of controlling or changing a member's environment. Also excluded is custodial care, domiciliary care, convalescent care or a rest cure that primarily assists an individual in the activities of daily living.
- Any treatment, service or supply that would have been covered had the individual obtained coverage required by law, i.e., coverage required under state workers' compensation or motor vehicle insurance laws. An individual who has not complied with such legal requirements will not be eligible for any benefits for that illness, injury or condition, including any re-injury, aggravation, etc.
- Any treatment, service, or supply provided to a member for whom the member would

not be held financially responsible in the absence of coverage.

- Any treatment, service or supply that was received as a result of the following:
 - (a) Violent conflicts. This includes participation in an insurrection, war (whether or not declared), military service, any civil disturbance, riot, piracy, hijack, or any and all acts incident to such events. "Participation" does not include being at the scene of such an event in the performance of your duties for the Company.
 - (b) Law violations. This means attempting to violate or violating criminal or motor vehicle laws, except where the violation was unwitting, unpremeditated, and without actual (as opposed to implied) criminal intent.
- Any treatment, service or supply that is received as a result of an accident, illness or injury arising out of or related to employment or self-employment for wage or profit.
 - Under workers' compensation, no-fault automobile coverage or similar legislation if you could elect it, or could have it elected for you;
 - While on active military duty; and
 - For treatment of military service-related disabilities when you are legally entitled to other coverage and facilities are reasonably accessible.
- Any treatment, service or supply which was or would have been covered had the individual obtained coverage by or through any government, including, to the extent permitted under present or future federal law, Medicare, or which was or would have been covered had the individual obtained coverage or taken advantage of any program offered by any government agency, i.e., Veterans Administration.
- Equipment ordinarily used for exercise, sport training, weight loss, recreation or similar personal purposes as opposed to therapeutic purposes is not covered, even if prescribed by a physician.
- Examination or treatment ordered by a court or in connection with legal proceedings unless such examination or treatment otherwise qualify as covered services.
- Charges for broken, canceled, or postponed appointments, or for the completion of claim forms or related documents required by the Plan for claims administration purposes or other Company-sponsored programs.
- Interest, finance charges, local or state sales taxes.
- Cosmetic, plastic or reconstructive surgery which improves, alters, or enhances appearance, unless required to correct congenital deformities which are outside the normal range of human variation; in connection with a mastectomy, or following a surgical procedure which is covered by the Plan and required as a result of an illness or injury.
- Dental services except those resulting from accidental injury to previously sound,

natural teeth.

- Preventive dental care.
- Diagnosis or treatment of the teeth or gums. Examples include: extractions (including wisdom teeth), restoration and replacement of teeth, medical or surgical treatments of dental conditions and services to improve dental clinical outcomes.
- Dental implants and braces.
- Treatment of malpositioned or supernumerary (extra) teeth, even if part of a congenital anomaly such as cleft lip or cleft palate.
- Direct or indirect expenses incurred for a dependent child's pregnancy.
- Education, special education or job training, even if given in a facility that also provides medical or psychiatric treatment.
- Evaluation procedures (such as x-rays and pulmonary function tests) in connection with applications for black lung benefits or required by black lung law or legislation.
- Unless specifically stated, holistic or homeopathic care including drugs and ecological or environmental medicine.
- Home obstetrical delivery.
- Hospital intern's or resident's services.
- Medical treatment not recommended or approved by a legally qualified physician.
- Limited treatment is available for endogenous and morbid obesity.
- Radial keratotomy, lasik surgery or any other surgical procedure for the correction of nearsightedness or similar vision problems.
- Routine eye examinations, refractions, or diagnostic procedures, including the fitting of eyeglasses or contact lenses.
- Any treatment, service or supply received in connection with a member acting as, or utilizing the services of, a surrogate mother.
- Any treatment, service or supply provided without cost or services for which you are not legally responsible.
- Any treatment, service or supply provided by a member of your immediate family or other individual who lives with you.
- Sex change surgery or gender identity disorders.
- Transportation services other than professionally licensed ambulance service.

- Vitamins (excluding pre-natal), minerals, food supplements, food substitutes, or medications that do not require a prescription and are not approved by the Food and Drug Administration except where indicated in covered services.
- Prescription drugs, mental health and/or substance abuse services, dental services and vision care services that are covered by the Prescription Drug Program, Mental Health and Substance Abuse Program, Dental Plans and the Vision Plan, respectively, are not covered by the medical plan.
- Alternative treatments such as acupuncture, aromatherapy, hypnosis, massage therapy, rolfing or other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
- Nutrition based therapy such as megavitamins excepts as described under Covered Health Services for Nutritional Counseling.
- The following treatments for obesity:
 - Non-surgical treatment, even if for morbid obesity; and
 - Surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under Obesity Surgery.
 - Other forms of alternative treatment as defined by the National Center for Complimentary and Alternative Medicine (NCCAM) of the National Institutes of Health.
- A procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy.
- Varicose vein treatment of the lower extremities, when it is considered cosmetic.
- Treatment of benign gynecomastia (abnormal breast enlargement in males).
- the reversal of voluntary sterilization.
- Food of any kind unless it is the only source of nutrition and it is specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU). Foods that are not covered include:
 - Enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk;
 - Foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes;
 - Oral vitamins and minerals;
 - Meals you can order from a menu, for an additional charge, during an inpatient hospital stay; and
 - Other dietary and electrolyte supplements.
- Performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license.

- Foreign language and sign language interpreters.
- Autopsies and other coroner services and transportation services for a corpse.
- Chelation therapy, except to treat heavy metal poisoning.
- Speech therapy to treat stuttering, stammering or other articulation disorders.
- Spinal treatment to treat a condition unrelated to alignment of the vertebral column, such as asthma or allergies.
- Storage of blood, umbilical cord or other materials for use in a Covered Health Service, except if needed for an imminent surgery.
- Non-surgical treatment for obesity, even if for morbid obesity.
- Provided at a diagnostic facility (hospital or free-standing) without a written order from a provider.
- Which are self-directed to a free-standing or hospital-based diagnostic facility.
- Treatment of hyperhidrosis (excessive sweating).
- Health services for organ and tissue transplants except as identified under *Transplant of Tissues and Organs* unless United Healthcare determines the transplant to be appropriate according to United Healthcare's transplant guidelines.