

hospital services for a live donor who specifically designates the Member recipient if the services are directly related to the transplant, other than corneal, subject to the following restrictions:

1. Preoperative evaluation, surgery, and follow-up care shall be provided at Plan centers having documented skills, resources, commitment and record of favorable outcomes to qualify the centers to provide such care;
2. Patients shall be selected by the patient-selection committee of the Plan facilities and subject to prior Authorization; and
3. Only anti-rejection drugs, biological products, and procedures that have been established as safe and effective, and not experimental or investigational, are covered.

Urgent Care Services

Urgent Care Services means those services performed, inside or outside the Plan's service area, which are medically required within a short timeframe, usually within twenty-four (24) hours, in order to prevent a serious deterioration of a Member's health due to an illness or injury or complication of an existing condition, including pregnancy, for which treatment cannot be delayed. Urgently needed services include maternity

services necessary to prevent serious deterioration of the health of the enrollee or the enrollee's fetus, based on the enrollee's reasonable belief that she has a pregnancy-related condition for which treatment cannot be delayed until the enrollee returns to the Plan's service area. Urgent care services received outside the Plan's service area are considered emergency services and do not require PCP authorization.

EXCLUDED BENEFITS

Exclusions and Limitations

The services and supplies listed below are exclusions (not Covered Benefits) or are covered with limitations (Covered Benefits only in specific instances) in addition to those already described in this Member Service Guide. Exclusions include any services or supplies that are:

- a. Not Medically Necessary
- b. Not specifically described in this Member Service Guide
- c. Specified as excluded in this Member Service Guide
- d. In excess of the limits described in this Member Service Guide
- e. Not provided by Plan Providers (except for Emergency or Authorized Urgent Care Services)

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- f. Not prescribed by a Plan Physician (except for Emergency Services) and, if required, Authorized in advance by your PCP or the Plan
- g. Part of a treatment plan for noncovered services
- h. Received prior to the Member's effective date of coverage or after the Member's termination from coverage under this plan.

Acupuncture, Acupressure and Biofeedback Services

Acupuncture, acupressure and biofeedback services are not covered.

Blood Services

Charges for the collection, processing, and storage of autologous (self-donated blood) are covered, but only when specifically collected for a planned and covered surgical procedure. Blood must be replaced according to local blood bank rules, unless no family member meets the medical criteria for blood donors.

Cancer Clinical Trials

The following services are not covered:

- The provision of non-FDA-approved drugs or devices that are the subject of the trial.
- Services other than health care services, such as travel, housing, and other non-clinical expenses that the Member may incur due to participation in the trial.

- Any item or service that is provided solely to satisfy data collection and/or analysis needs and that is not used in the clinical management of the Member.
- Health care services that are otherwise excluded from coverage (other than those that are excluded on the basis that they are experimental or investigational).
- Health care services that are customarily provided by the research sponsors free of charge for enrollees in the trial.

Chemical Dependency and Alcoholism Treatment

Short-term acute drug or alcohol detoxification is covered only as an Emergency Medical Condition.

Chiropractic Services

Chiropractic services are not covered.

Cosmetic and Reconstructive Surgical Services

- Cosmetic services or supplies that retard or reverse the effects of aging or hair loss, or alter or reshape normal structures of the body in order to improve appearance, are not covered.

- Implants are not covered, except for the following: cardiac pacemakers; intraocular lenses; screws; nuts; bolts; bands; nails; plates; and pins used for the fixation of fractures or osteotomies and artificial knees and hips; and except as otherwise described in the Covered Benefits section of this Member Handbook.

Custodial Care

Custodial care, domiciliary care, or rest cures, for which facilities of a general acute care hospital are not medically required, are not covered. Custodial care is care that does not require the regular services of trained medical or health professionals, such as but not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications that are ordinarily self-administered.

Dental Services/Oral Surgical Services

Dental services, including dental treatment for temporomandibular joint problems, are not covered, except for repair necessitated by accidental injury to sound natural teeth or jaw, provided that the repair commences within ninety (90) days after the accidental injury or as soon thereafter as is medically feasible.

Disposable Medical Supplies

Disposable medical supplies that are not provided in a hospital or physician office or by a home health professional are not covered.

Durable Medical Equipment

Comfort or convenience items are not covered (except ostomy bags and urinary catheters and supplies, including exercise and hygiene equipment; experimental or research equipment; devices not medical in nature such as sauna baths and elevators, or modifications to the home or automobile; deluxe equipment; or more than one piece of equipment that serve the same function.

Emergency Services

Emergency facility and professional services which are not required on an immediate basis for treatment of an Emergency Medical Condition are not covered.

Experimental or Investigational

Medical, surgical or other procedures, services, products, drugs, or devices (including implants) are not covered if they are:

- a. Experimental or investigational or not recognized in accord with generally accepted medical standards as being safe and effective for use in the treatment in question; or
- b. Outmoded or not efficacious, such as

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those defined by the federal Medicare and state Medicaid programs, or drugs or devices that are not approved by the Food and Drug Administration.

If a service is denied because it is deemed to be an investigational or experimental therapy, a terminally ill Member may be entitled to request an independent medical review of the Plan's decision. If you would like more information about the decision criteria, or if you would like a copy of the Plan's policy regarding independent medical reviews, please call our Member Service Department.

Please see the section titled "Cancer Clinical Trials" in the Covered Benefits portion of this Handbook for information about coverage of experimental or investigational treatments that are part of an eligible cancer clinical trial.

Eyeglasses

Eyeglasses are not covered, except those eyeglasses or contact lenses necessary after cataract surgery.

Hearing Services

Hearing aids and routine hearing examinations are not covered except as specifically listed as covered in this Member Service Guide. The purchase of batteries or other ancillary equipment, except those covered under the terms of the initial hearing aid purchase, and charges for a hearing aid that exceed specifications

prescribed for correction of a hearing loss are not covered. Replacement parts for hearing aids, repair of a hearing aid after the covered one-year warranty period, replacement of a hearing aid more than once in any period of 36 months, and surgically implanted hearing devices are excluded.

Home Health Services

Custodial care is excluded.

Hospital (Inpatient and Outpatient) Services

Private hospital rooms and personal comfort items are not covered unless Authorized by the Plan as Medically Necessary.

Long-Term Care

Long-term care, including long-term skilled nursing care in a licensed facility and respite care, are not covered unless specifically Authorized by the Plan as a satisfactory alternative to the basic benefits.

Mental Health Services

The following mental health services are not Covered Benefits:

- Any service covered under the Member's Employee Assistance Program (EAP).
- Any services performed or prescribed by anyone other than a Plan Provider (except for Emergency Services).

- Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation, custody, or visitation.
- Developmental disorders, including, but not limited to, developmental reading disorder, developmental arithmetic disorder, developmental language disorder, or developmental articulation disorder. Note that this exclusion does not apply to pervasive development disorder or autism, which are covered as Severe Mental Illnesses.
- Counseling for activities of an educational nature.
- Counseling for borderline intellectual functioning.
- Counseling for occupational problems.
- Counseling related to consciousness raising.
- Vocational or religious counseling.
- Counseling for marital problems.
- I.Q. testing.
- Psychological testing on children required as a condition of enrollment in school.
- Services or supplies provided outside the Service Area (except for Emergency Services).

Prosthetics and Orthotics

Corrective shoes and arch supports, except for therapeutic footwear for diabetics, are not covered. Non-rigid devices such as elastic knee supports, corsets, elastic stockings, and garter belts are not covered. Dental appliances and electronic voice producing machines are not covered. More than one device for the same part of the body is not covered.

Prescription Drugs

Drugs are not covered when prescribed to treat conditions that are excluded from coverage under the Program, except as required to treat a life-threatening or non-routine complication that arises from a non-covered service. Experimental or investigational drugs, unless accepted for use by the standards of the medical community, are not covered. Drugs or medications for cosmetic purposes and patent or over-the-counter medicines, including non-prescription contraceptive jellies, ointments, foams, and condoms, are not covered. Medicines not requiring a written prescription order (except insulin) are not covered.

Professional Services

Frequency of periodic health examinations will not be increased for reasons which are unrelated to the medical needs of the Member, including a Member's desire or

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request for physical examinations and reports or related services for the purpose of obtaining or maintaining employment, licenses, insurance or school sports clearance.

Transportation Services

Transportation services are not covered unless meeting the criteria for medical transportation services. Transportation by airplane, passenger car, taxi or other form of public conveyance is not covered unless Authorized by the Plan.

Vision Services

Vision benefits are not covered.

Other

The following services are not covered:

- Any services or items specified as excluded or in excess of limits described in the Covered Benefits section of this handbook.
- Court or employer-ordered care.
- Treatment for infertility. Diagnosis of infertility is not covered unless provided in conjunction with covered gynecological services. Treatments of medical conditions of the reproductive system are not excluded.
- Treatment for any bodily injury or

sickness arising from or sustained in the course of any occupation or employment for compensation, profit, or gain for which such benefits are provided or payable under any Worker's Compensation benefit plan. The Plan shall provide the services at the time of need, and the Member shall cooperate to assure that the Plan is reimbursed for such benefits.

- Services that are covered under or eligible for reimbursement by any other insurance or health care service plan. The Plan shall provide the services at the time of need, and the Member shall cooperate to assure that the Plan is reimbursed for such benefits.
- The frequency of routine health examinations will not be increased for reasons, which are unrelated to the medical needs of the Member. This includes the Member's desire or request for physical examinations, and reports or related services for the purpose of obtaining or continuing employment, licenses, insurance, or school sports clearance, travel licensure, camp, school admissions, recreational sports, premarital or pre-adoptive purposes, by court order, or for reasons not Medically Necessary.