



Benefit Summary

North Carolina - Choice Plus
Balanced - 25/1000/80% Plan S1E

We know that when people know more about their health and health care, they can make better informed health care decisions. We want to help you understand more about your health care and the resources that are available to you.

- **myuhc.com**[®] – Take advantage of easy, time-saving online tools. You can check your eligibility, benefits, claims, claim payments, search for a doctor and hospital and much, much more.
- **24-hour nurse support** – A nurse is a phone call away and you have other health resources available 24-hours a day, 7 days a week to provide you with information that can help you make informed decisions. Just call the number on the back of your ID card.
- **Customer Care telephone support** – Need more help? Call a customer care professional using the toll-free number on the back of your ID card. Get answers to your benefit questions or receive help looking for a doctor or hospital.

PLAN HIGHLIGHTS

Types of Coverage	Network Benefits	Non-Network Benefits
Annual Deductible		
Individual Deductible	\$1,000 per year	\$2,000 per year
Family Deductible	\$2,000 per year	\$4,000 per year

- > Member Copayments do not accumulate towards the Deductible.
- > All individual Deductible amounts will count toward the family Deductible, but an individual will not have to pay more than the individual Deductible amount.

Out-of-Pocket Maximum		
Individual Out-of-Pocket Maximum	\$3,000 per year	\$6,000 per year
Family Out-of-Pocket Maximum	\$6,000 per year	\$12,000 per year

- > Member Copayments do not accumulate towards the Out-of-Pocket Maximum.
- > All individual Out-of-Pocket Maximum amounts will count toward the family Out-of-Pocket Maximum, but an individual will not have to pay more than the individual Out-of-Pocket Maximum amount.
- > The Out-of-Pocket Maximum includes the Annual Deductible.

Benefit Plan Coinsurance - The Amount We Pay		
Coinsurance is the amount you pay (calculated on the lesser of the Eligible Expenses and the billed charges) each time you receive certain Covered Health Services.	80% after Deductible has been met.	60% after Deductible has been met.

This Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary conflicts in any way with the Certificate of Coverage (COC), the COC shall prevail. It is recommended that you review your COC 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.

NCWGJS1E07

Item#	Rev. Date	Benefit Accumulator	
430-4174	0807_rev07	Policy Year	PVY/Sep/Emb/53531

UnitedHealthcare Insurance Company

Maximum Policy Benefit

The maximum amount we will pay during the entire period of time you are enrolled under the Policy. No Maximum Benefit.

Prescription Drug Benefits

Prescription drug benefits are shown under separate cover.

Information on Benefit Limits

- > The Annual Deductible, Out-of-Pocket Maximum and Benefit limits are calculated on a Policy year basis.
- > All Benefits are reimbursed based on Eligible Expenses. For a definition of Eligible Expenses, please refer to your Certificate of Coverage.
- > When Benefit limits apply, the limit refers to any combination of Network and Non-Network Benefits unless specifically stated in the Benefit category.
- > Your actual expense for covered health care services may exceed the stated coinsurance percentage or copayment amount because actual provider charges may not be used to determine plan or insured payment obligations.

MOST COMMONLY USED BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Physician's Office Services - Sickness and Injury		
Primary Physician Office Visit	100% after you pay a \$25 Copayment per visit.	60% after Deductible has been met.
Specialist Physician Office Visit	100% after you pay a \$50 Copayment per visit.	60% after Deductible has been met.

> In addition to the visit Copayment, the applicable Copayment or Deductible/Coinsurance applies when these services are done: CT, PET, MRI, Nuclear Medicine; Scopic Procedures; Surgery; Therapeutic Treatments.

Preventive Care Services

Covered Health Services include but are not limited to:

Primary Physician Office Visit	100% Deductible does not apply.	60% after Deductible has been met.
Specialist Physician Office Visit	100% Deductible does not apply.	
Lab, X-Ray or other preventive tests	100% Deductible does not apply.	

Urgent Care Center Services

100% after you pay a \$75 Copayment per visit. 60% after Deductible has been met.

- > In addition to the visit Copayment, the applicable Copayment or Deductible/Coinsurance applies when these services are done: CT, PET, MRI, Nuclear Medicine; Scopic Procedures; Surgery; Therapeutic Treatments.

Emergency Health Services - Outpatient

100% after you pay a \$150 Copayment per visit. Emergency care received from a Non-Network provider will be paid at the in-network benefit level.
Pre-service Notification is required if results in an Inpatient Stay.

Hospital - Inpatient Stay

80% after Deductible has been met. 60% after Deductible has been met.

Pre-service Notification is required.

ADDITIONAL CORE BENEFITS

YOUR BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Ambulance Service - Emergency and Non-Emergency		
Ground Ambulance	80% after Deductible has been met.	Emergency care received from a Non-Network provider will be paid at the in-network benefit level.
Air Ambulance	80% after Deductible has been met.	Emergency care received from a Non-Network provider will be paid at the in-network benefit level.
	<i>Pre-service Notification is required for Non-Emergency Ambulance.</i>	<i>Pre-service Notification is required for Non-Emergency Ambulance.</i>
Congenital Heart Disease (CHD) Surgeries		
	80% after Deductible has been met.	60% after Deductible has been met.
		Benefits are limited to \$30,000 per surgery.
		<i>Pre-service Notification is required.</i>
Dental Services - Accident Only		
Benefits are limited as follows: \$3,000 maximum per year \$900 maximum per tooth	80% after Deductible has been met.	80% after Network Deductible has been met.
	<i>Pre-service Notification is required.</i>	<i>Pre-service Notification is required.</i>
Diabetes Services		
Diabetes Self Management and Training Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
Diabetes Self Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this Benefit Summary. Diabetes supplies and self-management services do not apply towards the Durable Medical Equipment category.	
		<i>Pre-service Notification is required for Durable Medical Equipment and Diabetes Equipment in excess of \$1,000.</i>
Durable Medical Equipment		
Benefits are limited as follows: \$2,500 per year and are limited to a single purchase of a type of Durable Medical Equipment (including repair and replacement) every three years.	80% after Deductible has been met.	60% after Deductible has been met.
		<i>Pre-service Notification is required for Durable Medical Equipment in excess of \$1,000.</i>

This benefit category contains services/devices that may be Essential or non-Essential Health Benefits as defined by the Patient Protection and Affordable Care Act depending upon the service or device delivered. A benefit review will take place once the dollar limit is exceeded. If the service/device is determined to be rehabilitative or habilitative in nature, it is an Essential Health Benefit and will be paid. If the benefit/device is determined to be non-essential, the maximum will have been met and the claim will not be paid.

ADDITIONAL CORE BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Hearing Aids		
Benefits are limited as follows: \$2,500 per year and are limited to a single purchase (including repair/ replacement) every three years. One hearing aid per ear up to \$2,500 per hearing aid every 36 months for Covered Persons under the age of 22.	80% after Deductible has been met.	60% after Deductible has been met.
Home Health Care		
Benefits are limited as follows: 60 visits per year	80% after Deductible has been met.	60% after Deductible has been met. <i>Pre-service Notification is required.</i>
Hospice Care		
	80% after Deductible has been met.	60% after Deductible has been met. <i>Pre-service Notification is required for Inpatient stays.</i>
Lab, X-Ray and Diagnostics - Outpatient		
For Preventive Lab, X-Ray and Diagnostics, refer to the Preventive Care Services category.	100% Deductible does not apply.	60% after Deductible has been met.
Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient		
	80% after Deductible has been met.	60% after Deductible has been met.
Ostomy Supplies		
Benefits are limited as follows: \$2,500 per year	80% after Deductible has been met.	60% after Deductible has been met.
Pharmaceutical Products - Outpatient		
This includes medications administered in an outpatient setting, in the Physician's Office and by a Home Health Agency.	80% after Deductible has been met.	60% after Deductible has been met.
Physician Fees for Surgical and Medical Services		
	80% after Deductible has been met.	60% after Deductible has been met.
Pregnancy - Maternity Services		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary. For services provided in the Physician's Office, a Copayment will only apply to the initial office visit.	<i>Pre-service Notification is required if the Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.</i>

ADDITIONAL CORE BENEFITS

YOUR BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Prosthetic Devices		
<p>Benefits are limited as follows: \$2,500 per year and are limited to a single purchase of each type of prosthetic device every three years.</p>	80% after Deductible has been met.	60% after Deductible has been met.
<p>This benefit category contains services/devices that may be Essential or non-Essential Health Benefits as defined by the Patient Protection and Affordable Care Act depending upon the service or device delivered. A benefit review will take place once the dollar limit is exceeded. If the service/device is determined to be rehabilitative or habilitative in nature, it is an Essential Health Benefit and will be paid. If the benefit/device is determined to be non-essential, the maximum will have been met and the claim will not be paid.</p>		
Reconstructive Procedures		
<p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.</p>		
Rehabilitation Services - Outpatient Therapy and Chiropractic Treatment		
<p>Benefits are limited as follows: 20 visits of chiropractic treatment 20 visits of physical therapy 20 visits of occupational therapy 20 visits of speech therapy 20 visits of pulmonary rehabilitation 36 visits of cardiac rehabilitation 30 visits of post-cochlear implant aural therapy</p>	<p>100% after you pay a \$25 Copayment per visit. When one Copayment applies to all services and Chiropractic Services are included, the Copayment must be the same as that applied for Physician Office Services, or Primary Care Physician under Physician Office Services when applicable.</p>	60% after Deductible has been met.
<p><i>Pre-service Notification is required for certain services.</i></p>		
Scopic Procedures - Outpatient Diagnostic and Therapeutic		
<p>Diagnostic scopic procedures include, but are not limited to: Colonoscopy Sigmoidoscopy Endoscopy</p>	80% after Deductible has been met.	60% after Deductible has been met.
<p>For Preventive Scopic Procedures, refer to the Preventive Care Services category.</p>	<p><i>Pre-service Notification is required.</i></p>	
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services		
<p>Benefits are limited as follows: 60 days per year</p>	80% after Deductible has been met.	60% after Deductible has been met.
<p><i>Pre-service Notification is required.</i></p>		
Surgery - Outpatient		
	80% after Deductible has been met.	60% after Deductible has been met.
Therapeutic Treatments - Outpatient		
<p>Therapeutic treatments include, but are not limited to: Dialysis Intravenous chemotherapy or other intravenous infusion therapy Radiation oncology</p>	80% after Deductible has been met.	<p>60% after Deductible has been met. <i>Pre-service Notification is required for certain services.</i></p>

ADDITIONAL CORE BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Transplantation Services	80% after Deductible has been met. For Network Benefits, services must be received at a Designated Facility. <i>Pre-service Notification is required.</i>	60% after Deductible has been met. Benefits are limited to \$30,000 per Transplant. <i>Pre-service Notification is required.</i>
Vision Examinations	100% after you pay a \$25 Copayment per visit.	60% after Deductible has been met.
Benefits are limited as follows: 1 exam every 2 years		

Types of Coverage	Network Benefits	Non-Network Benefits
Clinical Trials		
<p>Clinical trials costs for Health Services associated with participation in Phase II, Phase III and Phase IV Clinical Trials for patient research studies designed to evaluate new treatments, including prescription drugs that: Involve the treatment of life-threatening medical conditions; are medically indicated and preferable for that patient compared to available noninvestigational treatment alternatives; and have clinical and preclinical data that shows the trial will likely be more effective for that patient than available noninvestigational alternatives.</p>	<p>Depending upon where the Covered Health Service is provided, any applicable notification or authorization requirements will be the same as those stated under each Covered Health Service category in this Benefit Summary.</p>	
	<i>Pre-service Notification is required.</i>	<i>Pre-service Notification is required.</i>
Dental - Anesthesia and Hospital or Facility Charges		
	<p>Depending upon where the Covered Health Service is provided, any applicable notification or authorization requirements will be the same as those stated under each Covered Health Service category in this Benefit Summary.</p>	
	<i>Pre-service Notification is required.</i>	<i>Pre-service Notification is required.</i>
Mental Health Services		
<p>For groups with 50 or less total employees: Benefits are limited for Mental Health Services as follows:</p>	<p>For groups with 50 or less total employees: Inpatient: 80% after Deductible has been met.</p>	<p>For groups with 50 or less total employees: Inpatient: 60% after Deductible has been met.</p>
<p>30 days per year for Inpatient 30 visits per year for Outpatient</p>	<p>Outpatient: 100% after you pay a \$50 Copayment per visit.</p>	<p>Outpatient: 60% after Deductible has been met.</p>
<p>The following illnesses are not subject to any of the above durational limits: Bipolar Disorder, Major Depressive Disorder, Obsessive Compulsive Disorder, Paranoid and Other Psychotic Disorder, Schizoaffective Disorder, Schizophrenia, Post-Traumatic Stress Disorder, Anorexia Nervosa, and Bulimia.</p>		
<p>For groups with 51 or more total employees: Benefit limits do not apply</p>	<p>For groups with 51 or more total employees: Inpatient: 80% after Deductible has been met. Outpatient: 100% after you pay a \$25 Copayment per visit.</p>	<p>For groups with 51 or more total employees: Inpatient: 60% after Deductible has been met. Outpatient: 60% after Deductible has been met.</p>
		<p><i>Pre-service Notification is required from the Mental Health/Substance Use Disorder Designee.</i></p>

STATE MANDATED BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Neurobiological Disorders – Autism Spectrum Disorder Services		
For groups with 50 or less total employees: Benefits are limited as follows: 30 days per year for Inpatient 20 visits per year for Outpatient	For groups with 50 or less total employees: Inpatient: 80% after Deductible has been met. Outpatient: 100% after you pay a \$50 Copayment per visit.	For groups with 50 or less total employees: Inpatient: 60% after Deductible has been met. Outpatient: 60% after Deductible has been met.
For groups with 51 or more total employees: Benefit limits do not apply	For groups with 51 or more total employees: Inpatient: 80% after Deductible has been met. Outpatient: 100% after you pay a \$25 Copayment per visit.	For groups with 51 or more total employees: Inpatient: 60% after Deductible has been met. Outpatient: 60% after Deductible has been met.
		<i>Pre-service Notification is required from the Mental Health/Substance Use Disorder Designee.</i>
Substance Use Disorder Services		
	For groups with 50 or less total employees: Inpatient: 80% after Deductible has been met. Outpatient: 100% after you pay a \$50 Copayment per visit.	For groups with 50 or less total employees: Inpatient: 60% after Deductible has been met. Outpatient: 60% after Deductible has been met.
	For groups with 51 or more total employees: Inpatient: 80% after Deductible has been met. Outpatient: 100% after you pay a \$25 Copayment per visit.	For groups with 51 or more total employees: Inpatient: 60% after Deductible has been met. Outpatient: 60% after Deductible has been met.
		<i>Pre-service Notification is required from the Mental Health/Substance Use Disorder Designee.</i>
Temporomandibular Jaw Joint Disorder		
	Depending upon where the Covered Health Service is provided, any applicable notification or authorization requirements will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
	<i>Pre-service Notification is required.</i>	<i>Pre-service Notification is required.</i>

This Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary conflicts in any way with the Certificate of Coverage (COC), the COC shall prevail. It is recommended that you review your COC 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.

MEDICAL EXCLUSIONS

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

Alternative Treatments

Acupressure; acupuncture; aromatherapy; hypnotism; massage therapy; rolfing; art therapy, music therapy, dance therapy, horseback therapy; and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Chiropractic Treatment and osteopathic care for which Benefits are provided as described in Section 1 of the COC.

Dental

Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia). This exclusion does not apply to Benefits as described under Dental - Anesthesia and Hospital Facility in Section 1 of the COC. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only in Section 1 of the COC. This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Policy, limited to: Transplant preparation; prior to initiation of immunosuppressive drugs; the direct treatment of cancer or cleft palate. Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication. Endodontics, periodontal surgery and restorative treatment are excluded. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include: extraction, restoration, and replacement of teeth; medical or surgical treatment of dental conditions; and services to improve dental clinical outcomes. This exclusion does not apply to accidental-related dental services for which Benefits are provided as described under Dental Services - Accidental Only in Section 1 of the COC. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only in Section 1 of the COC. Dental braces (orthodontics). Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly.

Devices, Appliances and Prosthetics

Devices used specifically as safety items or to affect performance in sports-related activities. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics, cranial banding and some types of braces, including over-the-counter orthotic braces. The following items are excluded, even if prescribed by a Physician: blood pressure cuff/monitor; enuresis alarm; home coagulation testing equipment; non-wearable external defibrillator; trusses; ultrasonic nebulizers; and ventricular assist devices. Devices and computers to assist in communication and speech except for speech aid prosthetics and tracheo-esophageal voice prosthetics. Oral appliances for snoring. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill. This exclusion does not apply to Benefits as described under Diabetes Services in Section 1 of the COC. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to Benefits as described under Diabetes Services in Section 1 of the COC. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office. Over-the-counter drugs and treatments. Growth hormone therapy except for a Dependent Child who requires growth hormone to treat a Congenital Anomaly.

Experimental, Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition except as described under Clinical Trials in Section 1 of the COC. This exclusion does not apply to coverage of any drug solely on the basis that the drug has been prescribed for the treatment of a type of cancer for which the drug has not been approved by the FDA. The drug, however, must be approved by the FDA and must have been proven effective and accepted for treatment of the specific type of cancer for which the drug has been prescribed in any one of the following established reference compendia: The American Medical Association Drug Evaluation, The American Hospital Formulary Service Drug Information, The United States Pharmacopeia Drug Information.

MEDICAL EXCLUSIONS CONTINUED

Foot Care

Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under Diabetes Services in Section 1 of the COC. Nail trimming, cutting, or debriding. Hygienic and preventive maintenance foot care. Examples include: cleaning and soaking the feet; applying skin creams in order to maintain skin tone. This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes. Treatment of flat feet or subluxation of the foot. Shoes; shoe orthotics; shoe inserts and arch supports.

Medical Supplies

Prescribed or non-prescribed medical supplies and disposable supplies, except diabetic supplies. Please note that if you have an outpatient prescription drug rider that provides coverage for diabetic medications and supplies, benefits are available under the rider and not this medical plan. Examples of supplies that are excluded include: elastic stockings, ace bandages, gauze and dressings, urinary catheters. This exclusion does not apply to:

- Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under Durable Medical Equipment in Section 1 of the COC.
- Diabetic supplies for which Benefits are provided as described under Diabetes Services in Section 1 of COC.
- Ostomy supplies for which Benefits are provided as described under Ostomy Supplies in Section 1 of the COC.

Tubing and masks, except when used with Durable Medical Equipment as described under Durable Medical Equipment as described in Section 1 of the COC.

Mental Health

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Mental Health Services as treatments for V-code conditions as listed within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis. Educational/behavioral services that are habilitative and focused on primarily building skills and capabilities in communication, social interaction and learning. Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act.

Neurobiological Disorders – Autism Spectrum Disorders

Services as treatments of sexual dysfunction that are not due to organic disease and feeding disorders as listed in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Mental retardation as the primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act. Intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorder unless deemed medically necessary.

Nutrition

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

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

Enteral feedings, even if the sole source of nutrition. Infant formula and donor breast milk. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods).

Personal Care, Comfort or Convenience

Television; telephone; beauty/barber service; guest service. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include: air conditioners, air purifiers and filters, dehumidifiers; batteries and battery chargers; breast pumps; car seats; chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners; electric scooters; exercise equipment; home modifications such as elevators, handrails and ramps; hot tubs; humidifiers; Jacuzzis; mattresses; medical alert systems; motorized beds; music devices; personal computers, pillows; power-operated vehicles; radios; saunas; stair lifts and stair glides; strollers; safety equipment; speech generating devices; treadmills; vehicle modifications such as van lifts; video players, whirlpools.

MEDICAL EXCLUSIONS CONTINUED

Physical Appearance

Cosmetic Procedures. See the definition in Section 9 of the COC. Examples include: pharmacological regimens, nutritional procedures or treatments. Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). Skin abrasion procedures performed as a treatment for acne. Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. Treatment for skin wrinkles or any treatment to improve the appearance of the skin. Treatment for spider veins. Hair removal or replacement by any means. Treatment of benign gynecomastia (abnormal breast enlargement in males). Breast reduction except as coverage is required by the Women's Health and Cancer Right's Act of 1998 for which Benefits are described under Reconstructive Procedures in Section 1 of the COC. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded. Wigs regardless of the reason for the hair loss.

Procedures and Treatments

Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, and brachioplasty. Medical and surgical treatment of excessive sweating (hyperhidrosis). Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, or autism spectrum disorders. Psychosurgery. Sex transformation operations. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter. Biofeedback. Surgical and non-surgical treatment of obesity. Stand-alone multi-disciplinary smoking cessation programs.

Providers

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

Reproduction

Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility. Surrogate parenting, donor eggs, donor sperm and host uterus. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue. The reversal of voluntary sterilization.

Services Provided under Another Plan

Health services and supplies for the treatment of an Occupational Injury or sickness which are paid under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer or workers'compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act. If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness, or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.

Substance Use Disorders

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

MEDICAL EXCLUSIONS CONTINUED

Transplants

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

Travel

Health services provided in a foreign country, unless required as Emergency Health Services. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at our discretion. Travel and living expenses are reimbursed if you receive transplant services from a Designated Facility.

Types of Care

Multi-disciplinary pain management programs provided on an inpatient basis. Custodial care; domiciliary care. Private duty nursing. This means nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true: no skilled services are identified; skilled nursing resources are available in the facility; the skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose. Respite care; rest cures; services of personal care attendants. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

Purchase cost and fitting charge for eye glasses and contact lenses. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants). Eye exercise or vision therapy. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser, and other refractive eye surgery.

Bone anchored hearing aids except when either of the following applies; For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid. For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. More than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled under the Policy. Repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage criteria, other than for malfunctions.

All Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 9 of the COC. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when: required solely for purposes of career, school, sports or camp, travel, employment, insurance, marriage or adoption; related to judicial or administrative proceedings or orders; conducted for purposes of medical research except as described under Clinical Trials in Section 1 of the COC; required to obtain or maintain a license of any type. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. Health services received after the date your coverage under the Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Policy ended. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy. Charges in excess of Eligible Expenses or in excess of any specified limitation. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.

Preexisting Conditions (Applies only to groups of 50 or less employees)

Benefits for the treatment of a Preexisting Condition are excluded until the earlier of the following: The date you have had Continuous Creditable Coverage for 12 months; or the date you have had Continuous Creditable Coverage for 18 months if you are a Late Enrollee. This exclusion does not apply to Covered Persons under age 19.