

SAMPLE POLICY EXCLUSIONS

Section 3: What Is Not Covered?

Introduction

Your Booklet expressly excludes expenses for the following Health Care Services, supplies, drugs or charges. The following exclusions are in addition to any exclusions specified in the “What Is Covered?” section or any other section of the Booklet.

Abortions which are elective.

Adult Wellness preventive care or routine screening Services, except as specified under the Preventive Adult Wellness Services category on your Schedule of Benefits.

Arch Supports, shoe inserts designed to effect conformational changes in the foot or foot alignment, orthopedic shoes, over-the-counter, custom-made or built-up shoes, cast shoes, sneakers, ready-made compression hose or support hose, or similar type devices/appliances regardless of intended use, except for therapeutic shoes (including inserts and/or modifications) for the treatment of severe diabetic foot disease.

Assisted Reproductive Therapy (Infertility) including, but not limited to, associated Services, supplies, and medications for In Vitro Fertilization (IVF); Gamete Intrafallopian Transfer (GIFT) procedures; Zygote Intrafallopian Transfer (ZIFT) procedures; Artificial Insemination (AI); embryo transport; surrogate parenting; donor semen and related costs including collection and preparation; and infertility treatment medication.

Autopsy or postmortem examination Services, unless specifically requested by us.

Complementary or Alternative Medicine including, but not limited to, self-care or self-help training; homeopathic medicine and counseling; Ayurvedic medicine such as lifestyle modifications and purification therapies; traditional Oriental medicine including acupuncture; naturopathic medicine;

environmental medicine including the field of clinical ecology; chelation therapy; thermography; mind-body interactions such as meditation, imagery, yoga, dance, and art therapy; biofeedback; prayer and mental healing; manual healing methods such as the Alexander technique, aromatherapy, Ayurvedic massage, craniosacral balancing, Feldenkrais method, Hellerwork, polarity therapy, Reichian therapy, reflexology, rolfing, shiatsu, traditional Chinese massage, Trager therapy, trigger-point myotherapy, and biofield therapeutics; Reiki, SHEN therapy, and therapeutic touch; bioelectromagnetic applications in medicine; and herbal therapies.

Complications of Non-Covered Services, including the diagnosis or treatment of any Condition which is a complication of a non-covered Health Care Service (e.g., Health Care Services to treat a complication of cosmetic surgery are not covered).

Cosmetic Services, including any Service to improve the appearance or self-perception of an individual (except as covered under the Breast Reconstructive Surgery category), including and without limitation: cosmetic surgery and procedures or supplies to correct hair loss or skin wrinkling (e.g., Minoxidil, Rogaine, Retin-A), and hair implants/transplants.

Costs related to telephone consultations, failure to keep a scheduled appointment, or completion of any form and/or medical information.

Custodial Care and any Service of a custodial nature, including and without limitation: Health Care Services primarily to assist in the activities of daily living; rest homes; home companions or sitters; home parents; domestic maid services; respite care; and provision of Services which are for the sole purposes of allowing a family member or caregiver of a Covered Person to return to work.

Dental Care or treatment of the teeth or their supporting structures or gums, or dental procedures, including but not limited to: extraction of teeth (except as listed in the Dental Services category in the "What Is Covered?" section of this Booklet), restoration of teeth with or without fillings, crowns or other materials, bridges, cleaning of teeth, dental implants, dentures, periodontal or endodontic procedures, orthodontic treatment (e.g., braces), intraoral Prosthetic Devices, palatal expansion devices, bruxism appliances, and dental x-rays. This exclusion also applies to Phase II treatments (as defined by the American Dental Association) for TMJ dysfunction. This exclusion does not apply to an Accidental Dental Injury and the Child Cleft Lip and Cleft Palate Treatment Services categories as described in the "What Is Covered?" section.

Diabetic Equipment and Supplies used for the treatment of diabetes which are otherwise covered under a BCBSF Pharmacy Program Endorsement to this Benefit Booklet.

Drugs

1. Prescribed for uses other than the Food and Drug Administration (FDA) approved label indications. This exclusion does not apply to any drug that has been proven safe, effective and accepted for the treatment of the specific medical Condition for which the drug has been prescribed, as evidenced by the results of good quality controlled clinical studies published in at least two or more peer-reviewed full length articles in respected national professional medical journals. This exclusion also does not apply to any drug prescribed for the treatment of cancer that has been approved by the FDA for at least one indication, provided the drug is recognized for treatment of your particular cancer in a Standard Reference Compendium or recommended for treatment of your particular cancer in Medical Literature. Drugs prescribed for the treatment of cancer that have not been approved for any indication are excluded.
2. All drugs dispensed to, or purchased by, you from a pharmacy. This exclusion does not apply to drugs dispensed to you when:
 - a. you are an inpatient in a Hospital, Ambulatory Surgical Center, Skilled Nursing Facility, Psychiatric Facility or a Hospice facility;
 - b. you are in the outpatient department of a Hospital;
 - c. dispensed to your Physician for administration to you in the Physician's office and prior coverage authorization has been obtained (if required);
 - d. you are receiving Home Health Care according to a plan of treatment and the Home Health Care Agency bills us for such drugs, including Self-Administered Prescription Drugs that are rendered in connection with a nursing visit; and
 - e. defined by, and covered under, a BCBSF Pharmacy Program Endorsement to this Booklet.
3. Any non-prescription medicines, remedies, vaccines, biological products (except insulin), pharmaceuticals or chemical compounds, vitamins, mineral supplements, fluoride products, over-the-counter drugs, products, or health foods.
4. Any drug which is indicated or used for sexual dysfunction (e.g., Cialis, Levitra, Viagra, Caverject). The exception described in item number one above does not apply to sexual dysfunction drugs excluded under this paragraph.
5. Any Self-Administered Prescription Drug except when indicated as covered in the "What Is Covered?" section of this Benefit Booklet.
6. Blood or blood products used to treat hemophilia, except when provided to you for:
 - a. emergency stabilization;

- b. during a covered inpatient stay, or
- c. when proximately related to a surgical procedure.

The exceptions to the exclusion for drugs purchased or dispensed by a pharmacy described in subparagraph number two do not apply to hemophilia drugs excluded under this subparagraph.

- 7. Drugs, which require prior coverage authorization when prior coverage authorization is not obtained.
- 8. Specialty Drugs used to increase height or bone growth (e.g., growth hormone) except for Conditions of growth hormone deficiency documented with two abnormally low stimulation tests of less than 10 ng/ml and one abnormally low growth hormone dependent peptide or for Conditions of growth hormone deficiency associated with loss of pituitary function due to trauma, surgery, tumors, radiation or disease, or for state mandated use as in patients with AIDS.

Continuation of growth hormone therapy will not be covered except for Conditions associated with significant growth hormone deficiency when there is evidence of continued responsiveness to treatment. (See "What is Covered?" section for additional information.)

Experimental or Investigational Services, except as otherwise covered under the Bone Marrow Transplant provision of the Transplant Services category.

Food and Food Products prescribed or not, except as covered in the Enteral Formulas category of the "What Is Covered?" section.

Foot Care which is routine, including any Health Care Service, in the absence of disease. This exclusion includes, but is not limited to: non-surgical treatment of bunions; flat feet; fallen arches; chronic foot strain; trimming of toenails, corns or calluses.

General Exclusions include, but are not limited to:

- 1. any Health Care Service received prior to your Effective Date or after the date your coverage terminates;
- 2. any Health Care Service not within the service categories described in the "What Is Covered?" section, any rider, or Endorsement attached hereto, unless such Services are specifically required to be covered by applicable law;
- 3. any Health Care Service provided by a Physician or other health care Provider related to you by blood or marriage;
- 4. any Health Care Service which is not Medically Necessary, as determined by us and defined in this Booklet. The ordering of a Service by a health care Provider does not in itself, make such Service Medically Necessary or a Covered Service;
- 5. any Health Care Service rendered at no charge;
- 6. expenses for claims denied because we did not receive information requested from you regarding whether or not you have other coverage and the details of such coverage;
- 7. any Health Care Service to diagnose or treat a Condition which, directly or indirectly, resulted from or is in connection with:
 - a) Services that are not patient-specific, as determined solely by us;
 - b) war or an act of war, whether declared or not;
 - c) your participation in, or commission of, any act punishable by law as a misdemeanor or felony, or which constitutes riot, or rebellion;
 - d) your engaging in an illegal occupation;
 - e) Services received at military or government facilities; or

- f) Services received to treat a Condition arising out of your service in the armed forces, reserves and/or National Guard; or
 - g) the play or practice of collegiate or intercollegiate sports, including collegiate club sports and intramurals.
8. Health Care Services rendered because they were ordered by a court, unless such Services are Covered Services under this Benefit Booklet; and
 9. any Health Care Service rendered by or through a medical or dental department maintained by or on behalf of an employer, mutual association, labor union, trust, or similar person or group; and
 10. any Health Care Service rendered to Covered Students who specialize in the mental health field and who receive treatment as a part of their training in that field.

Genetic Screening including the evaluation of genes to determine if you are a carrier of an abnormal gene that puts you at risk for a Condition.

Hearing Aids (external or implantable) and Services related to the fitting or provision of hearing aids, including tinnitus maskers, batteries, and cost of repair.

Immunizations except those covered under the Preventive Child Health Supervision Services or Preventive Adult Wellness Services categories of the "What Is Covered?" section.

Maternity Services rendered to a Covered Person who becomes pregnant as a Gestational Surrogate under the terms of, and in accordance with, a Gestational Surrogacy Contract or Arrangement. This exclusion applies to all expenses for prenatal, intra-partial, and post-partial maternity/obstetrical care, and Health Care Services rendered to the Covered Person acting as a Gestational Surrogate.

For the definition of Gestational Surrogate and Gestational Surrogacy Contract or Arrangement, see the "Definitions" section of this Benefit Booklet.

Oral Surgery except as provided under the "What Is Covered?" section.

Orthomolecular Therapy including nutrients, vitamins, and food supplements.

Oversight of a medical laboratory by a Physician or other health care Provider.

"Oversight" as used in this exclusion shall include, but is not limited to, the oversight of:

1. the laboratory to assure timeliness, reliability, and/or usefulness of test results;
2. the calibration of laboratory machines or testing of laboratory equipment;
3. the preparation, review or updating of any protocol or procedure created or reviewed by a Physician or other health care Provider in connection with the operation of the laboratory; and
4. laboratory equipment or laboratory personnel for any reason.

Personal Comfort, Hygiene or Convenience Items and Services deemed to be not Medically Necessary and not directly related to your treatment including, but not limited to:

1. beauty and barber services;
2. clothing including support hose;
3. radio and television;
4. guest meals and accommodations;
5. telephone charges;
6. take-home supplies;
7. travel expenses (other than Medically Necessary Ambulance Services);
8. motel/hotel accommodations;
9. air conditioners, furnaces, air filters, air or water purification systems, water softening systems, humidifiers, dehumidifiers, vacuum

cleaners or any other similar equipment and devices used for environmental control or to enhance an environmental setting;

10. hot tubs, Jacuzzis, heated spas, pools, or memberships to health clubs;
11. heating pads, hot water bottles, or ice packs;
12. physical fitness equipment;
13. hand rails and grab bars; and
14. Massages except as covered in the "What Is Covered?" section of this Booklet.

Prescription Drug Copayments, Coinsurance and Deductibles, or any part thereof, you are obligated to pay under any plan or policy.

Private Duty Nursing Care rendered at any location.

Rehabilitative Therapies provided on an inpatient or outpatient basis, except as provided in the Hospital, Skilled Nursing Facility, Home Health Care, and Outpatient Cardiac, Occupational, Physical, Speech, Massage Therapies and Spinal Manipulations categories of the "What Is Covered?" section. Rehabilitative Therapies provided for the purpose of maintaining rather than improving your Condition are also excluded.

Reversal of Voluntary, Surgically-Induced Sterility including the reversal of tubal ligations and vasectomies.

Sexual Reassignment, or Modification Services including, but not limited to, any Health Care Services related to such treatment, such as psychiatric Services.

Smoking Cessation Programs including any Service to eliminate or reduce the dependency on, or addiction to, tobacco, including but not limited to nicotine withdrawal programs and nicotine products (e.g., gum, transdermal patches, etc.).

Sports-Related devices and Services used to affect performance primarily in sports-related activities; all expenses related to physical

conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation.

Training and Educational Programs, or materials, including, but not limited to programs or materials for Pain Management and vocational rehabilitation, except as provided under the Diabetes Outpatient Self-Management category of the "What Is Covered?" section.

Travel or vacation expenses, even if prescribed or ordered by a Provider.

Volunteer Services or Services which would normally be provided free of charge and any charges associated with Deductible, Coinsurance, or Copayment (if applicable) requirements which are waived by a health care Provider.

Weight Control Services including any Service to lose, gain, or maintain weight regardless of the reason for the Service or whether the Service is part of a treatment plan for a Condition. This exclusion includes, but is not limited to weight control/loss programs; appetite suppressants and other medications; dietary regimens; food or food supplements; exercise programs; exercise or other equipment; gastric or stomach bypass or stapling, intestinal bypass, gastric balloons, jaw wiring, jejunal bypass, gastric shunts, and procedures designed to restrict your ability to assimilate food.

Wigs and/or cranial prosthesis.

Work Related Health Care Services to treat a work related Condition to the extent you are covered; or required to be covered by Workers' Compensation law. Any Service to diagnose or treat any Condition resulting from or in connection with your job or employment are excluded, except for Medically Necessary Services (not otherwise excluded) for an individual who is not covered by Workers' Compensation and that lack of coverage did not result from any intentional action or omission by that individual.