United HealthCare Services, Inc. and The George Washington University want to help you take control and make the most of your health care benefits. That’s why we provide convenient services to get your health care questions answered quickly and accurately:

- 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 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.

The 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 Summary Plan Description (SPD), the SPD shall prevail. It is recommended that you review your SPD 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.

### PLAN HIGHLIGHTS

#### Types of Coverage

<table>
<thead>
<tr>
<th>Network Benefits</th>
<th>Non-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Deductible</td>
<td>$2,000 per year</td>
</tr>
<tr>
<td>Deductible</td>
<td>$3,000 per year</td>
</tr>
<tr>
<td>Family Coverage Deductible</td>
<td>$4,000 per year</td>
</tr>
</tbody>
</table>
- No one in the family is eligible for benefits until the family coverage deductible is met.

#### Out-of-Pocket Maximum – Combined Medical and Pharmacy

<table>
<thead>
<tr>
<th>Network Benefits</th>
<th>Non-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single Coverage Out-of-Pocket Maximum</td>
<td>$4,000 per year</td>
</tr>
<tr>
<td>Deductible</td>
<td>$6,000 per year</td>
</tr>
<tr>
<td>Family Coverage Out-of-Pocket Maximum</td>
<td>$7,150 per year</td>
</tr>
<tr>
<td>Deductible</td>
<td>$12,000 per year</td>
</tr>
</tbody>
</table>
- The Out-of-Pocket Maximum includes the Annual Deductible.
- If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply.
- Copayments, Coinsurance and Deductibles accumulate towards the Out-of-Pocket Maximum.
- Prescription Drug cost shares are included in the Medical Out-of-Pocket Maximum.

#### Benefit Plan Coinsurance – The Amount the Plan Pays

<table>
<thead>
<tr>
<th>Network Benefits</th>
<th>Non-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>80% after Deductible has been met</td>
<td></td>
</tr>
<tr>
<td>60% after Deductible has been met</td>
<td></td>
</tr>
</tbody>
</table>

#### Prescription Drug Benefits

Prescription drug benefits are shown under separate cover. Benefits are not payable for Prescriptions until the Deductible above has been met.

Information of Pre-service Notification

*Prior Authorization is required for certain services. (Note that only genetic testing for BRCA requires prior authorization for Non-Network services under the Physician’s Services category)

**Prior Authorization is required for Equipment in excess of $1,000.

Information on Benefit Limits

- The Annual Deductible, Out-of-Pocket Maximum and Benefit limits are calculated on a calendar year basis.
- Refer to your Summary Plan Description for a definition of Eligible Expenses and information on how benefits are paid.
- When Benefit limits apply, the limit refers to any combination of Network and Non-Network Benefits unless specifically stated in the Benefit category.

### BENEFITS

<table>
<thead>
<tr>
<th>Network Benefits</th>
<th>Non-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance Services – Emergency and Non-Emergency</td>
<td>80% after Deductible has been met</td>
</tr>
<tr>
<td>Dental Services – Accident Only</td>
<td>80% after Deductible has been met</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME)</td>
<td>80% after Deductible has been met</td>
</tr>
<tr>
<td>Emergency Health Services - Outpatient</td>
<td>80% after Deductible has been met</td>
</tr>
<tr>
<td>80% after Network Deductible has been met</td>
<td></td>
</tr>
</tbody>
</table>

SFXGFTT707PA
<table>
<thead>
<tr>
<th>Types of Coverage</th>
<th>Network Benefits</th>
<th>Non-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hearing Aids</strong></td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Home Health Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limited 100 visits per year</td>
<td>80% after Deductible has been met</td>
<td>* 60% after Deductible has been met</td>
</tr>
<tr>
<td><strong>Hospice Care</strong></td>
<td>80% after Deductible has been met</td>
<td>* 60% after Deductible has been met</td>
</tr>
<tr>
<td><strong>Hospital – Inpatient Stay</strong></td>
<td>80% after Deductible has been met</td>
<td>* 60% after Deductible has been met</td>
</tr>
<tr>
<td><strong>Lab, X-Ray and Diagnostics – Outpatient</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>For Preventive Lab, X-Ray and Diagnostics, refer to the Preventive Care Services category.</td>
<td>Free Standing Facilities and GW Hospital -80% after deductible has been met</td>
<td>* 60% after Deductible has been met</td>
</tr>
<tr>
<td><strong>Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine – Outpatient</strong></td>
<td>Free Standing Facilities and GW Hospital -80% after deductible has been met</td>
<td>* 60% after Deductible has been met</td>
</tr>
<tr>
<td><strong>Mental Health Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient:</td>
<td>80% after Deductible has been met</td>
<td>* 60% after Deductible has been met</td>
</tr>
<tr>
<td>Outpatient:</td>
<td>80% after Deductible has been met</td>
<td>* 60% after Deductible has been met</td>
</tr>
<tr>
<td><strong>Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient:</td>
<td>80% after Deductible has been met</td>
<td>* 60% after Deductible has been met</td>
</tr>
<tr>
<td>Outpatient:</td>
<td>80% after Deductible has been met</td>
<td>* 60% after Deductible has been met</td>
</tr>
<tr>
<td><strong>Pharmaceutical Products - Outpatient</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>This includes medications administered in an outpatient setting, in the Physician’s Office or in a Covered Person’s home.</td>
<td>80% after Deductible has been met</td>
<td>60% after Deductible has been met</td>
</tr>
<tr>
<td><strong>Physician Fees for Surgical and Medical Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>80% after Deductible has been met</td>
<td>60% after Deductible has been met</td>
<td></td>
</tr>
<tr>
<td><strong>Physician’s Office Services – Sickness and Injury</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Physician Office Visit</td>
<td>80% after Deductible has been met</td>
<td>* 60% after Deductible has been met</td>
</tr>
<tr>
<td>Specialist Physician Office Visit</td>
<td>80% after Deductible has been met</td>
<td>* 60% after Deductible has been met</td>
</tr>
<tr>
<td><strong>Pregnancy – Maternity Services</strong></td>
<td>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.</td>
<td>Prior Authorization is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.</td>
</tr>
<tr>
<td><strong>Preventive Care Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Covered Health Services include but are not limited to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Physician Office Visit</td>
<td>100% Deductible does not apply.</td>
<td>60% after Deductible has been met</td>
</tr>
<tr>
<td>Specialist Physician Office Visit</td>
<td>100% Deductible does not apply.</td>
<td>60% after Deductible has been met</td>
</tr>
<tr>
<td>Lab, X-Ray or other preventive tests</td>
<td>100% Deductible does not apply.</td>
<td>60% after Deductible has been met</td>
</tr>
<tr>
<td><strong>Prosthetic Devices</strong></td>
<td>80% after Deductible has been met</td>
<td>60% after Deductible has been met</td>
</tr>
<tr>
<td><strong>Reconstructive Procedures</strong></td>
<td>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.</td>
<td>Prior Authorization is required.</td>
</tr>
<tr>
<td><strong>Rehabilitation Services – Outpatient Therapy and Manipulative Treatment</strong></td>
<td>Benefits are limited as follows:</td>
<td>60% after Deductible has been met</td>
</tr>
<tr>
<td>60 visits of physical therapy, occupational therapy and speech therapy combined,</td>
<td>50% after Deductible has been met</td>
<td>* 60% after Deductible has been met</td>
</tr>
<tr>
<td>60 visits of manipulative treatment</td>
<td>60% after Deductible has been met</td>
<td></td>
</tr>
<tr>
<td>20 visits of pulmonary rehabilitation</td>
<td>60% after Deductible has been met</td>
<td></td>
</tr>
<tr>
<td>36 visits of cardiac rehabilitation</td>
<td>60% after Deductible has been met</td>
<td></td>
</tr>
<tr>
<td>Unlimited visits of post-cochlear implant aural therapy</td>
<td>60% after Deductible has been met</td>
<td></td>
</tr>
<tr>
<td>Unlimited visits of Vision Therapy (Orthoptic)</td>
<td>60% after Deductible has been met</td>
<td></td>
</tr>
<tr>
<td>The limits stated above include habilitative services.</td>
<td>60% after Deductible has been met</td>
<td></td>
</tr>
<tr>
<td><strong>Scopic Procedures – Outpatient Diagnostic and Therapeutic</strong></td>
<td>80% after Deductible has been met</td>
<td>60% after Deductible has been met</td>
</tr>
</tbody>
</table>
**MEDICAL EXCLUSIONS**

It is recommended that you review your SPD 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.

**Experimental or Investigational or Unproven Services**

For Network Benefits, services must be received at a Designated Facility.

**Surgery – Outpatient**

For Network Benefits, services must be received at a Designated Facility.

**Non-Network Benefits**

For Preventive Scopic Procedures, refer to the Preventive Services in the SPD.

**Skilled Nursing Facility / Inpatient Rehabilitation Facility Services**

Benefits are limited as follows:

- 100 days per year

**Drug Free Smoking Program**

Services for smoking cessation, and weight control classes.

**Non-Network Benefits**

For Network Benefits, services must be received at a Designated Facility.

**Substance Use Disorder Services**

Inpatient: 80% after Deductible has been met

Outpatient: 80% after Deductible has been met

Non-Network Benefits are not available

**Substance Use Disorder Services**

Inpatient: 80% after Deductible has been met

Outpatient: 80% after Deductible has been met

**Nutrition**

Supplements that are not approved by the National Institutes of Health. This exclusion does not apply to Manipulative treatment and non-manipulative osteopathic care for which Benefits are provided as described in the SPD.

**Dental**

Examples include: extraction (including wisdom teeth), 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 accident-related dental services for which Benefits are provided as described under Dental Services – Accident Only in the SPD. 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 the SPD. Dental braces (orthodontics). Congenital Anomaly such as cleft lip or cleft palate.

**Devices, Appliances and Prosthetics**

Inpatient: 80% after Deductible has been met

Outpatient: 80% after Deductible has been met

**Surgery – Outpatient**

For Network Benefits, services must be received at a Designated Facility.

**Non-Network Benefits**

For Network Benefits, services must be received at a Designated Facility.

**Substance Use Disorder Services**

Inpatient: 80% after Deductible has been met

Outpatient: 80% after Deductible has been met

**Network Benefits**

For Preventive Scopic Procedures, refer to the Preventive Services in the SPD.

**Skilled Nursing Facility / Inpatient Rehabilitation Facility Services**

Benefits are limited as follows:

- 100 days per year

**MEDICAL EXCLUSIONS**

It is recommended that you review your SPD 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.

**Laser Therapy**

It is recommended that you review your SPD 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.

**Urgent Care Center Services**

80% after Deductible has been met

**Personal Care, Comfort or Convenience**

- Aromatherapy; hypnotism; massage therapy; rolling (pneumatic tissue massage); art, music, dance, 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 Manipulative treatment and non-manipulative osteopathic care for which Benefits are provided as described in the SPD.

**Devices, Appliances and Prosthetics**

Examples of evidence-based conditions as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Manipulative treatment and non-manipulative osteopathic care for which Benefits are provided as described in the SPD. Chiropractic care that is not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered Experimental; such as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Manipulative treatment and non-manipulative osteopathic care for which Benefits are provided as described in the SPD.

**Dental**

Examples include: cleaning and soaking the feet; applying skin creams in order to maintain skin integrity; devices and computers to assist in communication and speech except for speech generating devices and tracheo-esophageal voice devices for which Benefits are provided as described under Underwriting for Speech Generating Devices. shoes (standard or custom), lifts and wedges; shoe orthotics; shoe inserts and arch supports.

**Nutrition**

Following items are excluded: blood pressure cuff/monitor; enuresis alarm; non-wearable external defibrillator; trusses; and urostomies. Inpatient: 80% after Deductible has been met

Outpatient: 80% after Deductible has been met

**Dental**

Lenses and contact lenses as specified in the SPD. 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 the SPD. Dental braces (orthodontics). Congenital Anomaly such as cleft lip or cleft palate.

**Devices, Appliances and Prosthetics**

This exclusion does not apply toclassed or licensed professional in an out of pocket setting. 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 therapies.

**Urgent Care Center Services**

80% after Deductible has been met

**Non-Network Benefits**

For Network Benefits, services must be received at a Designated Facility.

**Substance Use Disorder Services**

Inpatient: 80% after Deductible has been met

Outpatient: 80% after Deductible has been met

**Non-Network Benefits**

For Network Benefits, services must be received at a Designated Facility.

**Substance Use Disorder Services**

Inpatient: 80% after Deductible has been met

Outpatient: 80% after Deductible has been met

**Non-Network Benefits**

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**Substance Use Disorder Services**

Inpatient: 80% after Deductible has been met

Outpatient: 80% after Deductible has been met

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**Substance Use Disorder Services**

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Outpatient: 80% after Deductible has been met

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**Substance Use Disorder Services**

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Inpatient: 80% after Deductible has been met

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**Non-Network Benefits**

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**Substance Use Disorder Services**

Inpatient: 80% after Deductible has been met

Outpatient: 80% after Deductible has been met

**Non-Network Benefits**

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**Substance Use Disorder Services**

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Outpatient: 80% after Deductible has been met

**Non-Network Benefits**

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**Substance Use Disorder Services**

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**Non-Network Benefits**

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**Substance Use Disorder Services**

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**Substance Use Disorder Services**

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**Substance Use Disorder Services**

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Outpatient: 80% after Deductible has been met

**Non-Network Benefits**

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**Substance Use Disorder Services**

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Outpatient: 80% after Deductible has been met

**Non-Network Benefits**

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**Substance Use Disorder Services**

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Outpatient: 80% after Deductible has been met

**Non-Network Benefits**

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**Substance Use Disorder Services**

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Outpatient: 80% after Deductible has been met

**Non-Network Benefits**

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**Substance Use Disorder Services**

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Outpatient: 80% after Deductible has been met

**Non-Network Benefits**

For Network Benefits, services must be received at a Designated Facility.

**Substance Use Disorder Services**

Inpatient: 80% after Deductible has been met

Outpatient: 80% after Deductible has been met

**Non-Network Benefits**

For Network Benefits, services must be received at a Designated Facility.
Cosmetic Procedures. See the definition in the SPD. 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), Skinabrasion procedures performed as a treatment for hair loss, varicose vein treatment of the lower extremities, when it is considered cosmetic; 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. Replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Treatment of benign gynecomastia (abnormal breast enlargement in males). Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, health club memberships and programs, spa treatments 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, even if for morbid obesity. Wigs regardless of the reason for the hair loss, except for temporary loss of hair resulting from loss of treatment of a malignancy.

Exclusions

- Procedure or surgery to remove fatty tissue such as panniculoplasty, abdominoplasty, thighplasty, brachioplasty, or mastopexy. 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 excess weight, including liposuction. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. Rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment. 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. Speech therapy to treat stuttering, stammering or other articulation disorders. Psychosurgery. 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. Manipulative treatment to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain and improve function, such as asthma or allergies. Manipulative treatment (the therapeutic application of chiropractic and osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function). Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be dental in nature, the following services for the diagnoses and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; dental restorations. Upper and lower jawline surgery, orthognathic surgery and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons because of a Congenital Anomaly, acute traumatic injury, dislocation, cancer, obstructive sleep apnea. Orthognathic surgery (procedure to correct underbite or overbite) and jaw alignment. Breast reduction except surgery as coverage is required by the Women's Health and Cancer Rights' Act of 1998 for which Benefits are described under Reconstructive Procedures in the SPD. Non-surgical treatment of obesity even if for morbid obesity. Surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under Obesity Surgery in the SPD. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings. Chemotherapy, except to treat heavy metal poisoning.

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 ordered or delivered by a Christian Science practitioner. Services performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license. Services provided at a free-standing or Hospital-based diagnostic facility with 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.

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. The following infertility treatment-related services: cryopreservation and other forms of preservation of reproductive materials, long-term storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue, and testicular tissue, donor services. 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 removal of voluntary sterilization. Health services and associated expenses for elective surgical, non-surgical, or drug-induced pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage). Services provided by a doula (labor aide) and parenting, prenatal or birthing classes. Artificial reproduction treatments done for genetic or eugenic.

Services Provided under Another Plan

- Health services for which other coverage is available under another plan, except for Eligible Expenses payable as described in the SPD. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation. If coverage under workers' compensation, no-fault automobile coverage or similar legislation is optional for you because you could elect it, or could have elected it for you. 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.

Fertility

- Health services for organ or tissue transplants, except as identified under Transplantation Services in the SPD unless UnitedHealthCare Services, Inc. determines the transplant to be appropriate according to UnitedHealthCare Services, Inc.'s transplant guidelines. Mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available), and donor costs for organ or tissue transplantation to another person (these costs may be covered under your benefit plan). Transplants

- Health services for organ and tissue transplants, except as identified under Transplantation Services in the SPD unless UnitedHealthCare Services, Inc. determines the transplant to be appropriate according to UnitedHealthCare Services, Inc.'s transplant guidelines. Mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available), and donor costs for organ or tissue transplantation to another person (these costs may be covered under your benefit plan).

Health services provided in a foreign country, unless required as Emergency Health Services. Travel or transportation expenses, even if ordered by a Physician, except as identified under Travel and Lodging in the SPD. Additional travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described in the SPD.

Rehabilitation

- Services provided under a Multi-disciplinary pain management program provided on an inpatient basis for acute pain or for exacerbation of chronic pain. Custodial care; domiciliary care. Private Duty Nursing. Respite care.

Reproduction

- This exclusion does not apply to nurse care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for Benefits that are described under Hospice Care in the SPD. 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 associated fitting charge for eye glasses and contact lenses. Implantable lenses used only to correct a refractive error (such as intraocular implants). Purchase cost and associated fitting and testing charges for hearing aids. Bone Anchor Hearing Aids (BAHA) and all other hearing assistive devices. 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 or for Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. Eye exercises or vision therapy. Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

All Other Exclusions

- Health services and supplies that do not meet the definition of a Covered Health Service – see the definition of Covered Health Services in the Glossary in the SPD. Covered Health Services are those health services including services, supplies or Prescription Drugs, which the Claims Administrator determines to be all of the following: Medically Necessary; described as a Covered Health Service in the SPD; and not otherwise excluded in the SPD. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when: required solely for purposes of education, school or sports, camp or travel, career or employment, insurance, marriage or adoption; or as a result of incarceration; related to judicial or administrative proceedings or orders; conducted for purposes of research; required to obtain or maintain a license of any type. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described in the SPD. 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. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone. Health services received after the date your coverage under the Plan 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 Plan 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 Plan. Charges that exceed Eligible Expenses or any specified limitation in the SPD. Foreign language and sign language services. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service. For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization. Health services when a provider waives the Copay, Annual Deductible or Coinsurance amounts. Autopsies and other coroner services and transportation services for a corpse. Charges for: missed appointments; room or facility reservations; completion of claim forms; or record processing. Charges prohibited by federal anti-kickback or self-referral status. Diagnostic tests that are: delivered in other than a Physician's office or health care facility; and self-administered home diagnostic tests, including but not limited to HIV and pregnancy tests. Vision therapy when rendered in connection with behavioral health disorders, including but not limited to: learning and reading disabilities; attention deficit/hyperactivity disorder; TBI or dyslexia.