

Health Insurance Summary

Effective 4/1/2007 - 3/31/2008

	Choice Plus 038 <i>In Network</i>	Choice 044 <i>In Network</i>	Choice Plus 059 <i>In Network</i>
Annual Deductible	None	None	None
Coinsurance	100%	100%	80%
Office Visit copay	\$15	\$20	\$15
Emergency Room copay	\$75	\$100	\$100
Max Contract Benefit	No Max	No Max	No Max
Out of Pocket Maximum	\$1500pp/\$3000pf	\$1000pp/\$2000pf	\$1500pp/\$3000pf
Prescription Drug copays	\$10/\$25/\$40	\$10/\$25/\$40	\$10/\$25/\$40
	Out of Network	Out of Network	Out of Network
Annual Deductible	\$1000pp/\$2000pf	N/A	\$500pp/\$1000pf
Coinsurance	70%		60%
Office Visit copay	30% of elig expenses		40% of elig expenses
Out of Pocket Maximum	\$4000pp/\$8000pf		\$3000pp/\$6,000pf
Max Contract Benefit	\$1,000,000pp		\$1,000,000pp

Premium Paid by Employee

	Choice Plus 038 <i>Biweekly</i>	Choice 044 <i>Biweekly</i>	Choice Plus 059 <i>Biweekly</i>
Employee Only	\$0.00	\$0.00	\$0.00
Employee + Spouse	\$212.48	\$197.56	\$183.95
Employee + Child(ren)	\$169.98	\$143.12	\$118.62
Employee + Family	\$382.46	\$340.68	\$302.57
	Monthly	Monthly	Monthly
Employee Only	\$0.00	\$0.00	\$0.00
Employee + Spouse	\$424.96	\$395.12	\$367.89
Employee + Child(ren)	\$339.96	\$286.24	\$237.24
Employee + Family	\$764.92	\$681.36	\$605.13

Vision Coverage

Discount offered for all Plans	
Vision Exam	Paid in full after current copay
Frames	Preferred pricing or 10-15% discount
Standard Lenses	Preferred pricing
Contact Lenses	
Fitting, Follow Up	Up to 20% discount
Contact Lenses (non-disp.)	Up to 20% discount
Contact Lenses (disposable)	No discount
Laser Vision Correction	Up to 15% discount

UnitedHealthcare Choice Plan 044

Choice plan gives you the freedom to see any Physician or other health care professional from our Network, including specialists, without a referral. With this plan, you will receive the highest level of benefits when you seek care from a network physician, facility or other health care professional. In addition, you do not have to worry about any claim forms or bills.

Some of the Important Benefits of Your Plan:

You have access to a Network of physicians, facilities and other health care professionals, including specialists, without designating a Primary Physician or obtaining a referral.

Benefits are available for office visits and hospital care, as well as inpatient and outpatient surgery.

Care CoordinationSM services are available to help identify and prevent delays in care for those who might need specialized help.

Emergencies are covered anywhere in the world.

Pap smears are covered.

Prenatal care is covered.

Routine check-ups are covered.

Childhood immunizations are covered.

Mammograms are covered.

Vision and hearing screenings are covered.

Choice Benefits Summary

Types of Coverage

Benefits / Copayment Amounts

This Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine coverage. This benefit plan may not cover all of your health care expenses. **More complete descriptions of Benefits and the terms under which they are provided are contained in the Certificate of Coverage that you will receive upon enrolling in the Plan.**

If this Benefit Summary conflicts in any way with the Contract issued to your employer, the Contract shall prevail.

Terms that are capitalized in the Benefit Summary are defined in the Certificate of Coverage.

Benefits are payable for Covered Health Services provided by or under the direction of your Network physician.

*Prior Notification is required for certain services.

Annual Deductible: No Annual Deductible.

Out-of-Pocket Maximum: \$1,000 per Covered Person per calendar year, not to exceed \$2,000 for all Covered Persons in a family. Copayments for some Covered Health Services will never apply to the Out-of-Pocket Maximum as specified in Section 1 of the COC.

Maximum Contract Benefit: No Maximum Policy Benefit.

1. Ambulance Services - Emergency only	Ground Transportation: No Copayment Air Transportation: 0% of Eligible Expenses
2. Dental Services - Accident only	*No Copayment *Prior notification is required before follow-up treatment begins.
3. Durable Medical Equipment Benefits for Durable Medical Equipment are limited to \$2,500 per calendar year. Limits do not apply to Durable Medical Equipment classified as diabetic equipment or supplies.	No Copayment
4. Emergency Health Services	\$100 per visit
5. Eye Examinations Refractive eye examinations are limited to one every other calendar year from a Network Provider.	\$20 per visit
6. Home Health Care Benefits are limited to 60 visits for skilled care services per calendar year.	No Copayment
7. Hospice Care Benefits are limited to 360 days during the entire period of time a Covered Person is covered under the Policy.	No Copayment
8. Hospital - Inpatient Stay	\$250 per Inpatient Stay
9. Injections Received in a Physician's Office	\$20 per visit
10. Maternity Services	Same as 8, 11, 12 and 13 No Copayment applies to Physician office visits for prenatal care after the first visit.
11. Outpatient Surgery, Diagnostic and Therapeutic Services Outpatient Surgery Outpatient Diagnostic Services Outpatient Diagnostic/Therapeutic Services - CT Scans, Pet Scans, MRI and Nuclear Medicine Outpatient Therapeutic Treatments	No Copayment No Copayment For lab and radiology/Xray: No Copayment No Copayment No Copayment
12. Physician's Office Services Covered Health Services for preventive medical care. Covered Health Services for the diagnosis and treatment of a Sickness or Injury received in a Physician's office.	\$20 per visit. No Copayment applies when a Physician charge is not assessed. \$20 per visit. No Copayment applies when a Physician charge is not assessed.
13. Professional Fees for Surgical and Medical Services	No Copayment
14. Prosthetic Devices Benefits for prosthetic devices are limited to \$2,500 per calendar year.	No Copayment
15. Reconstructive Procedures	Same as 8, 11, 12, 13 and 14

Types of Coverage	Benefits / Copayment Amounts
16. Rehabilitation Services - Outpatient Therapy Benefits are limited as follows: 20 visits of physical therapy; 20 visits of occupational therapy; 20 visits of speech therapy; 20 visits of pulmonary rehabilitation; and 36 visits of cardiac rehabilitation per calendar year.	\$20 per visit
17. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Benefits are limited to 60 days per calendar year.	No Copayment
18. Transplantation Services	*No Copayment
19. Urgent Care Center Services	\$50 per visit

Additional Benefits

Bones or Joints of the Jaw and Facial Region	Same as 8, 11, 12 and 13
Child Health Supervision Services Coverage from birth to age 16.	Same as 11, 12 and 13 No Annual Deductible applies.
Cleft Lip/Cleft Palate Treatment	Same as 8, 11, 12, 13, and 16
Dental Procedures - Anesthesia and Hospitalization	Same as 8, 11, and 13
Diabetes Treatment	Same as 3, 11, 12 and 13
Mammography	No Copayment
Mastectomy	Same as 8, 11, 12 and 13
Mental Health and Substance Abuse Services - Outpatient Must receive prior authorization through the Mental Health/Substance Abuse Designee. Benefits are limited to 30 visits per calendar year.	\$20 per individual visit; \$15 per group visit.
Mental Health and Substance Abuse Services - Inpatient and Intermediate Must receive prior authorization through the Mental Health/Substance Abuse Designee. Benefits are limited to 30 days per calendar year.	\$250 per Inpatient Stay
Osteoporosis Treatment	Same as 11, 12 and 13
Prescription and Non-Prescription Enteral Formulas Benefits for low protein food products for Covered Persons through age 24 are limited to \$2,500 per calendar year.	No Copayment
Spinal Treatment Benefits include diagnosis and related services and are limited to one visit and treatment per day. Benefits are limited to 24 visits per calendar year.	\$20 per visit

Except as may be specifically provided in Section 1 of the Certificate of Coverage (COC) or through a Rider to the Contract, the following are not covered:

A. Alternative Treatments

Acupressure; hypnosis; rolfing; massage therapy; aromatherapy; acupuncture; and other forms of alternative treatment.

B. Comfort or Convenience

Personal comfort or convenience items or services such as television; telephone; barber or beauty service; guest service; supplies, equipment and similar incidental services and supplies for personal comfort including air conditioners, air purifiers and filters, batteries and battery chargers, humidifiers and dehumidifiers; devices or computers to assist in communication and speech.

C. Dental

Except as specifically described as covered in Section 1 of the COC under the headings Dental Services - Accident only and Cleft Lip/Cleft Palate Treatment, dental services are excluded. There is no coverage for services provided for the prevention, diagnosis, and treatment of the teeth or gums (including extraction, restoration, and replacement of teeth and services to improve dental clinical outcomes). Dental implants and dental braces are excluded. Dental x-rays, supplies and appliances and all associated expenses arising out of such dental services (including hospitalizations and anesthesia) are excluded, except as might otherwise be required for transplant preparation, initiation of immunosuppressives, the direct treatment of acute traumatic Injury, cancer, or cleft palate, or as described in Section 1 of the COC under the heading of Dental Procedures - Anesthesia and Hospitalization. Treatment for congenitally missing, malpositioned, or super numerary teeth is excluded, even if part of a Congenital Anomaly except in connection with cleft lip or cleft palate.

D. Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill. Self-injectable medications except as described in Section 1 of the COC under the heading of Diabetes Treatment. Non-injectable medications given in a Physician's office except as required in an Emergency. Over-the-counter drugs and treatments.

E. Experimental, Investigational or Unproven Services

Experimental, Investigational or Unproven Services are excluded, except (a) bone marrow transplants and (b) medically appropriate medications prescribed for the treatment of cancer, for a particular indication, if that drug is recognized for the treatment of that indication in a standard reference compendium or recommended in medical literature. The fact that an Experimental, 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, Investigational or Unproven in the treatment of that particular condition.

F. Foot Care

Routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting, or debriding; hygienic and preventive maintenance foot care; treatment of flat feet or subluxation of the foot; shoe orthotics.

G. Medical Supplies and Appliances

Devices used specifically as safety items or to affect performance primarily in sports-related activities. Prescribed or non-prescribed medical supplies and disposable supplies including but not limited to elastic stockings, ace bandages, gauze and dressings, ostomy supplies, syringes except as described under Section 1 of the COC under the heading Diabetes Treatment. Orthotic appliances that straighten or re-shape a body part (including cranial banding and some types of braces). Tubings and masks are not covered except when used with Durable Medical Equipment as described in Section 1 of the COC.

H. Mental Health/Substance Abuse

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment, or crisis intervention. Mental Health treatment of insomnia and other sleep disorders, neurological disorders, and other disorders with a known physical basis.

Treatment of conduct and impulse control disorders, personality disorders, paraphilias and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Abuse Designee.

Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Mental Health/Substance Abuse Designee. Residential treatment services. Services or supplies that in the reasonable judgment of the Mental Health/Substance Abuse Designee are not, for example, consistent with certain national standards or professional research further described in Section 2 of the COC.

I. Nutrition

Megavitamin and nutrition based therapy; nutritional counseling for either individuals or groups, except as described in Section 1 under the heading Diabetes Treatment. Enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk. Enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk except as described in Section 1 under the heading Prescription and Non-prescription Enteral Formulas.

J. Physical Appearance

Cosmetic Procedures including, but not limited to, pharmacological regimens; nutritional procedures or treatments; salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, and/or which are performed as a treatment for acne. Replacement of an existing breast implant is excluded if the earlier breast implant was a Cosmetic Procedure. (Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy.) Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation. Weight loss programs for medical and non-medical reasons. Wigs, regardless of the reason for the hair loss.

K. Providers

Services performed by a provider with your same legal residence or who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider as further described in Section 2 of the COC (this exclusion does not apply to mammography testing).

L. Reproduction

Health services and associated expenses for infertility treatments. Surrogate parenting. The reversal of voluntary sterilization.

M. Services Provided under Another Plan

Health services for which other coverage is paid under arrangements required by federal, state or local law. This includes, but is not limited to, coverage paid by workers' compensation, no-fault automobile insurance, or similar legislation. 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.

N. Transplants

Health services for organ or tissue transplants are excluded, except those specified as covered in Section 1 of the COC. Any solid organ transplant that is performed as a treatment for cancer. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. Health services for transplants involving mechanical or animal organs. Transplant services that are not performed at a Designated Facility. Any multiple organ transplant not listed as a Covered Health Service in Section 1 of the COC.

O. 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 transplantation services may be reimbursed at our discretion.

P. Vision and Hearing

Purchase cost of eye glasses, contact lenses, or hearing aids. Fitting charge for hearing aids, eye glasses or contact lenses. Eye exercise therapy. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.

Q. Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service - see definition in Section 10 of the COC.

Physical, psychiatric or psychological examinations, testing, vaccinations, immunizations or treatments otherwise covered under the Policy, when such services are: (1) required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption; (2) relating to judicial or administrative proceedings or orders; (3) conducted for purposes of medical research; or (4) 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 Contract ends, including health services for medical conditions arising prior to the date your coverage under the Contract ends.

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.

Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature except as described in Section 1 of the COC under the heading Bones or Joints of the Jaw and Facial Region.

Surgical treatment and non-surgical treatment of obesity (including morbid obesity).

Growth hormone therapy; sex transformation operations; treatment of benign gynecomastia (abnormal breast enlargement in males); medical and surgical treatment of excessive sweating (hyperhidrosis); medical and surgical treatment for snoring, except when provided as part of treatment for documented obstructive sleep apnea. Oral appliances for snoring. Custodial care; domiciliary care; private duty nursing; respite care; rest cures.

Psychosurgery. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cleft lip/cleft palate or Congenital Anomaly.

UnitedHealthcare Choice Plus *Plan 038*

Choice Plus plan gives you the freedom to see any Physician or other health care professional from our Network, including specialists, without a referral. With this plan, you will receive the highest level of benefits when you seek care from a network physician, facility or other health care professional. In addition, you do not have to worry about any claim forms or bills.

You also may choose to seek care outside the Network, without a referral. However, you should know that care received from a non-network physician, facility or other health care professional means a higher deductible and Copayment. In addition, if you choose to seek care outside the Network, UnitedHealthcare only pays a portion of those charges and it is your responsibility to pay the remainder. This amount you are required to pay, which could be significant, does not apply to the Out-of-Pocket Maximum. We recommend that you ask the non-network physician or health care professional about their billed charges *before you receive care*.

Some of the Important Benefits of Your Plan:

You have access to a Network of physicians, facilities and other health care professionals, including specialists, without designating a Primary Physician or obtaining a referral.

Benefits are available for office visits and hospital care, as well as inpatient and outpatient surgery.

Care CoordinationSM services are available to help identify and prevent delays in care for those who might need specialized help.

Emergencies are covered anywhere in the world.

Pap smears are covered.

Prenatal care is covered.

Routine check-ups are covered.

Childhood immunizations are covered.

Mammograms are covered.

Vision and hearing screenings are covered.

Choice Plus Benefits Summary

Types of Coverage	Network Benefits / Copayment Amounts	Non-Network Benefits / Copayment Amounts
<p>This Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine coverage. This benefit plan may not cover all of your health care expenses. More complete descriptions of Benefits and the terms under which they are provided are contained in the Certificate of Coverage that you will receive upon enrolling in the Plan.</p> <p>If this Benefit Summary conflicts in any way with the Contract issued to your employer, the Contract shall prevail.</p> <p>Terms that are capitalized in the Benefit Summary are defined in the Certificate of Coverage.</p> <p>Where Benefits are subject to day, visit and/or dollar limits, such limits apply to the combined use of Benefits whether in-Network or out-of-Network, except where mandated by state law.</p> <p>Network Benefits are payable for Covered Health Services provided by or under the direction of your Network physician.</p> <p>*Prior Notification is required for certain services.</p>	<p>UnitedHealthcare of Florida, Inc. is financially responsible for Network Benefits.</p> <p>Annual Deductible: No Annual Deductible.</p> <p>Out-of-Pocket Maximum: \$1,500 per Covered Person per calendar year, not to exceed \$3,000 for all Covered Persons in a family. Copayments for some Covered Health Services will never apply to the Out-of-Pocket Maximum as specified in Section 1 of the COC.</p> <p>Maximum Contract Benefit: No Maximum Policy Benefit.</p>	<p>UnitedHealthcare of Florida, Inc. is financially responsible for Non-Network Benefits.</p> <p>Annual Deductible: \$1,000 per Covered Person per calendar year, not to exceed \$2,000 for all Covered Persons in a family.</p> <p>Out-of-Pocket Maximum: \$4,000 per Covered Person per calendar year, not to exceed \$8,000 for all Covered Persons in a family. The Out-of-Pocket Maximum does not include the Annual Deductible. Copayments for some Covered Health Services will never apply to the Out-of-Pocket Maximum as specified in Section 1 of the COC.</p> <p>Maximum Contract Benefit: \$1,000,000 per Covered Person.</p>
1. Ambulance Services - Emergency only	Ground Transportation: No Copayment Air Transportation: 0% of Eligible Expenses	Same as Network Benefit
2. Dental Services - Accident only	*No Copayment *Prior notification is required before follow-up treatment begins.	*30% of Eligible Expenses *Prior notification is required before follow-up treatment begins.
3. Durable Medical Equipment Network and Non-Network Benefits for Durable Medical Equipment are limited to \$2,500 per calendar year. Limits do not apply to Durable Medical Equipment classified as diabetic equipment or supplies.	No Copayment	*30% of Eligible Expenses *Prior notification is required when the cost is more than \$1,000.
4. Emergency Health Services	\$75 per visit	Same as Network Benefit *Notification is required if results in an Inpatient Stay.
5. Eye Examinations Refractive eye examinations are limited to one every other calendar year from a Network Provider.	\$15 per visit	30% of Eligible Expenses Eye Examinations for refractive errors are not covered.
6. Home Health Care Network and Non-Network Benefits are limited to 60 visits for skilled care services per calendar year.	No Copayment	*30% of Eligible Expenses
7. Hospice Care Network and Non-Network Benefits are limited to 360 days during the entire period of time a Covered Person is covered under the Policy.	No Copayment	*30% of Eligible Expenses
8. Hospital - Inpatient Stay	\$250 per Inpatient Stay	*30% of Eligible Expenses
9. Injections Received in a Physician's Office	\$15 per visit	30% per injection
10. Maternity Services	Same as 8, 11, 12 and 13 No Copayment applies to Physician office visits for prenatal care after the first visit.	Same as 8, 11, 12 and 13 *Notification is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.
11. Outpatient Surgery, Diagnostic and Therapeutic Services		
Outpatient Surgery	No Copayment	30% of Eligible Expenses
Outpatient Diagnostic Services	For lab and radiology/Xray: No Copayment	30% of Eligible Expenses
Outpatient Diagnostic/Therapeutic Services - CT Scans, Pet Scans, MRI and Nuclear Medicine	No Copayment	30% of Eligible Expenses
Outpatient Therapeutic Treatments	No Copayment	30% of Eligible Expenses
12. Physician's Office Services		
Covered Health Services for preventive medical care.	\$15 per visit. No Copayment applies when a Physician charge is not assessed.	30% of Eligible Expenses. No Benefits for preventive care, except Child Health Supervision Services.
Covered Health Services for the diagnosis and treatment of a Sickness or Injury received in a Physician's office.	\$15 per visit. No Copayment applies when a Physician charge is not assessed.	30% of Eligible Expenses

YOUR BENEFITS

Types of Coverage	Network Benefits / Copayment Amounts	Non-Network Benefits / Copayment Amounts
13. Professional Fees for Surgical and Medical Services	No Copayment	30% of Eligible Expenses
14. Prosthetic Devices Network and Non-Network Benefits for prosthetic devices are limited to \$2,500 per calendar year.	No Copayment	30% of Eligible Expenses
15. Reconstructive Procedures	Same as 8, 11, 12, 13 and 14	*Same as 8, 11, 12, 13 and 14
16. Rehabilitation Services - Outpatient Therapy Network and Non-Network Benefits are limited as follows: 20 visits of physical therapy; 20 visits of occupational therapy; 20 visits of speech therapy; 20 visits of pulmonary rehabilitation; and 36 visits of cardiac rehabilitation per calendar year.	\$15 per visit	30% of Eligible Expenses
17. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Network and Non-Network Benefits are limited to 60 days per calendar year.	No Copayment	*30% of Eligible Expenses
18. Transplantation Services	*No Copayment	*30% of Eligible Expenses
19. Urgent Care Center Services	\$35 per visit	30% of Eligible Expenses

Additional Benefits

Bones or Joints of the Jaw and Facial Region	Same as 8, 11, 12 and 13	*Same as 8, 11, 12 and 13
Child Health Supervision Services Coverage from birth to age 16.	Same as 11, 12 and 13 No Annual Deductible applies.	Same as 11, 12 and 13 No Annual Deductible applies.
Cleft Lip/Cleft Palate Treatment	Same as 8, 11, 12, 13, and 16	*Same as 8, 11, 12, 13 and 16
Dental Procedures - Anesthesia and Hospitalization	Same as 8, 11, and 13	*Same as 8, 11, and 13
Diabetes Treatment	Same as 3, 11, 12 and 13	Same as 3, 11, 12 and 13
Mammography	No Copayment	No Copayment
Mastectomy	Same as 8, 11, 12 and 13	*Same as 8, 11, 12 and 13
Mental Health and Substance Abuse Services - Outpatient Must receive prior authorization through the Mental Health/Substance Abuse Designee. Benefits are limited to 30 visits per calendar year.	\$15 per individual visit; \$10 per group visit.	No Benefits
Mental Health and Substance Abuse Services - Inpatient and Intermediate Must receive prior authorization through the Mental Health/Substance Abuse Designee. Benefits are limited to 30 days per calendar year.	\$250 per Inpatient Stay	No Benefits
Osteoporosis Treatment	Same as 11, 12 and 13	Same as 11, 12 and 13
Prescription and Non-Prescription Enteral Formulas Benefits for low protein food products for Covered Persons through age 24 are limited to \$2,500 per calendar year.	No Copayment	30% of Eligible Expenses
Spinal Treatment Benefits include diagnosis and related services and are limited to one visit and treatment per day. Network and Non-Network Benefits are limited to 24 visits per calendar year.	\$15 per visit	30% of Eligible Expenses

Except as may be specifically provided in Section 1 of the Certificate of Coverage (COC) or through a Rider to the Contract, the following are not covered:

A. Alternative Treatments

Acupressure; hypnosis; rolfing; massage therapy; aromatherapy; acupuncture; and other forms of alternative treatment.

B. Comfort or Convenience

Personal comfort or convenience items or services such as television; telephone; barber or beauty service; guest service; supplies, equipment and similar incidental services and supplies for personal comfort including air conditioners, air purifiers and filters, batteries and battery chargers, dehumidifiers and humidifiers; devices or computers to assist in communication and speech.

C. Dental

Except as specifically described as covered in Section 1 of the COC under the headings Dental Services - Accident only and Cleft Lip/Cleft Palate Treatment, dental services are excluded. There is no coverage for services provided for the prevention, diagnosis, and treatment of the teeth or gums (including extraction, restoration, and replacement of teeth and services to improve dental clinical outcomes). Dental implants and dental braces are excluded. Dental x-rays, supplies and appliances and all associated expenses arising out of such dental services (including hospitalizations and anesthesia) are excluded, except as might otherwise be required for transplant preparation, initiation of immunosuppressives, the direct treatment of acute traumatic Injury, cancer, or cleft palate, or as described in Section 1 of the COC under the heading of Dental Procedures - Anesthesia and Hospitalization. Treatment for congenitally missing, malpositioned, or super numerary teeth is excluded, even if part of a Congenital Anomaly except in connection with cleft lip or cleft palate.

D. Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill. Self-injectable medications except as described in Section 1 of the COC under the heading of Diabetes Treatment. Non-injectable medications given in a Physician's office except as required in an Emergency. Over-the-counter drugs and treatments.

E. Experimental, Investigational or Unproven Services

Experimental, Investigational or Unproven Services are excluded, except (a) bone marrow transplants and (b) medically appropriate medications prescribed for the treatment of cancer, for a particular indication, if that drug is recognized for the treatment of that indication in a standard reference compendium or recommended in medical literature. The fact that an Experimental, 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, Investigational or Unproven in the treatment of that particular condition.

F. Foot Care

Routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting, or debriding; hygienic and preventive maintenance foot care; treatment of flat feet or subluxation of the foot; shoe orthotics.

G. Medical Supplies and Appliances

Devices used specifically as safety items or to affect performance primarily in sports-related activities. Prescribed or non-prescribed medical supplies and disposable supplies including but not limited to elastic stockings, ace bandages, gauze and dressings, ostomy supplies, syringes except as described under Section 1 of the COC under the heading Diabetes Treatment. Orthotic appliances that straighten or re-shape a body part (including cranial banding and some types of braces). Tubings and masks are not covered except when used with Durable Medical Equipment as described in Section 1 of the COC.

H. Mental Health/Substance Abuse

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment, or crisis intervention. Mental Health treatment of insomnia and other sleep disorders, neurological disorders, and other disorders with a known physical basis.

Treatment of conduct and impulse control disorders, personality disorders, paraphilias and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Abuse Designee.

Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Mental Health/Substance Abuse Designee. Residential treatment services. Services or supplies that in the reasonable judgment of the Mental Health/Substance Abuse Designee are not, for example, consistent with certain national standards or professional research further described in Section 2 of the COC.

I. Nutrition

Megavitamin and nutrition based therapy; nutritional counseling for either individuals or groups, except as described in Section 1 under the heading Diabetes Treatment. Enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk. Enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk except as described in Section 1 under the heading Prescription and Non-prescription Enteral Formulas.

J. Physical Appearance

Cosmetic Procedures including, but not limited to, pharmacological regimens; nutritional procedures or treatments; salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, and/or which are performed as a treatment for acne. Replacement of an existing breast implant is excluded if the earlier breast implant was a Cosmetic Procedure. (Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy.) Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation. Weight loss programs for medical and non-medical reasons. Wigs, regardless of the reason for the hair loss.

K. Providers

Services performed by a provider with your same legal residence or who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider as further described in Section 2 of the COC (this exclusion does not apply to mammography testing).

L. Reproduction

Health services and associated expenses for infertility treatments. Surrogate parenting. The reversal of voluntary sterilization.

M. Services Provided under Another Plan

Health services for which other coverage is paid under arrangements required by federal, state or local law. This includes, but is not limited to, coverage paid by workers' compensation, no-fault automobile insurance, or similar legislation. 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.

N. Transplants

Health services for organ or tissue transplants are excluded, except those specified as covered in Section 1 of the COC. Any solid organ transplant that is performed as a treatment for cancer. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. Health services for transplants involving mechanical or animal organs. Transplant services that are not performed at a Designated Facility. Any multiple organ transplant not listed as a Covered Health Service in Section 1 of the COC.

O. 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 transplantation services may be reimbursed at our discretion.

P. Vision and Hearing

Purchase cost of eye glasses, contact lenses, or hearing aids. Fitting charge for hearing aids, eye glasses or contact lenses. Eye exercise therapy. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.

Q. Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service - see definition in Section 10 of the COC.

Physical, psychiatric or psychological examinations, testing, vaccinations, immunizations or treatments otherwise covered under the Policy, when such services are: (1) required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption; (2) relating to judicial or administrative proceedings or orders; (3) conducted for purposes of medical research; or (4) 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 Contract ends, including health services for medical conditions arising prior to the date your coverage under the Contract ends.

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 Contract. In the event that a Non-Network provider waives Copayments and/or the Annual Deductible for a particular health service, no Benefits are provided for the health service for which Copayments and/or the Annual Deductible are waived.

Charges in excess of Eligible Expenses or in excess of any specified limitation.

Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature except as described in Section 1 of the COC under the heading Bones or Joints of the Jaw and Facial Region.

Surgical treatment and non-surgical treatment of obesity (including morbid obesity).

Growth hormone therapy; sex transformation operations; treatment of benign gynecomastia (abnormal breast enlargement in males); medical and surgical treatment of excessive sweating (hyperhidrosis); medical and surgical treatment for snoring, except when provided as part of treatment for documented obstructive sleep apnea. Oral appliances for snoring. Custodial care; domiciliary care; private duty nursing; respite care; rest cures.

Psychosurgery. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cleft lip/cleft palate or Congenital Anomaly.

UnitedHealthcare Choice Plus *Plan 059*

Choice Plus plan gives you the freedom to see any Physician or other health care professional from our Network, including specialists, without a referral. With this plan, you will receive the highest level of benefits when you seek care from a network physician, facility or other health care professional. In addition, you do not have to worry about any claim forms or bills.

You also may choose to seek care outside the Network, without a referral. However, you should know that care received from a non-network physician, facility or other health care professional means a higher deductible and Copayment. In addition, if you choose to seek care outside the Network, UnitedHealthcare only pays a portion of those charges and it is your responsibility to pay the remainder. This amount you are required to pay, which could be significant, does not apply to the Out-of-Pocket Maximum. We recommend that you ask the non-network physician or health care professional about their billed charges *before you receive care*.

Some of the Important Benefits of Your Plan:

You have access to a Network of physicians, facilities and other health care professionals, including specialists, without designating a Primary Physician or obtaining a referral.

Benefits are available for office visits and hospital care, as well as inpatient and outpatient surgery.

Care CoordinationSM services are available to help identify and prevent delays in care for those who might need specialized help.

Emergencies are covered anywhere in the world.

Pap smears are covered.

Prenatal care is covered.

Routine check-ups are covered.

Childhood immunizations are covered.

Mammograms are covered.

Vision and hearing screenings are covered.

Choice Plus Benefits Summary

Types of Coverage	Network Benefits / Copayment Amounts	Non-Network Benefits / Copayment Amounts
<p>This Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine coverage. This benefit plan may not cover all of your health care expenses. More complete descriptions of Benefits and the terms under which they are provided are contained in the Certificate of Coverage that you will receive upon enrolling in the Plan.</p> <p>If this Benefit Summary conflicts in any way with the Policy issued to your employer, the Policy shall prevail. Terms that are capitalized in the Benefit Summary are defined in the Certificate of Coverage.</p> <p>Where Benefits are subject to day, visit and/or dollar limits, such limits apply to the combined use of Benefits whether in-Network or out-of-Network, except where mandated by state law.</p> <p>Network Benefits are payable for Covered Health Services provided by or under the direction of your Network physician.</p> <p>*Prior Notification is required for certain services.</p>	<p>Annual Deductible: No Annual Deductible.</p> <p>Out-of-Pocket Maximum: \$1,500 per Covered Person per calendar year, not to exceed \$3,000 for all Covered Persons in a family. Copayments for some Covered Health Services will never apply to the Out-of-Pocket Maximum as specified in Section 1 of the COC.</p> <p>Maximum Policy Benefit: No Maximum Policy Benefit.</p>	<p>Annual Deductible: \$500 per Covered Person per calendar year, not to exceed \$1,000 for all Covered Persons in a family.</p> <p>Out-of-Pocket Maximum: \$3,000 per Covered Person per calendar year, not to exceed \$6,000 for all Covered Persons in a family. The Out-of-Pocket Maximum does not include the Annual Deductible. Copayments for some Covered Health Services will never apply to the Out-of-Pocket Maximum as specified in Section 1 of the COC.</p> <p>Maximum Policy Benefit: \$1,000,000 per Covered Person.</p>
1. Ambulance Services - Emergency only	Ground Transportation: 20% of Eligible Expenses Air Transportation: 20% of Eligible Expenses	Same as Network Benefit
2. Dental Services - Accident only	*20% of Eligible Expenses *Prior notification is required before follow-up treatment begins.	*Same as Network Benefit *Prior notification is required before follow-up treatment begins.
3. Durable Medical Equipment Network and Non-Network Benefits for Durable Medical Equipment are limited to \$2,500 per calendar year. Limits do not apply to Durable Medical Equipment classified as diabetic equipment or supplies.	20% of Eligible Expenses	*40% of Eligible Expenses *Prior notification is required when the cost is more than \$1,000.
4. Emergency Health Services	\$100 per visit	Same as Network Benefit *Notification is required if results in an Inpatient Stay.
5. Eye Examinations Refractive eye examinations are limited to one every other calendar year from a Network Provider.	\$15 per visit	40% of Eligible Expenses Eye Examinations for refractive errors are not covered.
6. Home Health Care Network and Non-Network Benefits are limited to 60 visits for skilled care services per calendar year.	20% of Eligible Expenses	*40% of Eligible Expenses
7. Hospice Care Network and Non-Network Benefits are limited to 360 days during the entire period of time a Covered Person is covered under the Policy.	20% of Eligible Expenses	*40% of Eligible Expenses
8. Hospital - Inpatient Stay	20% of Eligible Expenses	*40% of Eligible Expenses
9. Injections Received in a Physician's Office	\$15 per visit	40% per injection
10. Maternity Services	Same as 8, 11, 12 and 13 No Copayment applies to Physician office visits for prenatal care after the first visit.	Same as 8, 11, 12 and 13 *Notification is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.
11. Outpatient Surgery, Diagnostic and Therapeutic Services		
Outpatient Surgery	20% of Eligible Expenses	40% of Eligible Expenses
Outpatient Diagnostic Services	For lab and radiology/Xray: No Copayment	40% of Eligible Expenses
Outpatient Diagnostic/Therapeutic Services - CT Scans, Pet Scans, MRI and Nuclear Medicine	20% of Eligible Expenses	40% of Eligible Expenses
Outpatient Therapeutic Treatments	20% of Eligible Expenses	40% of Eligible Expenses
12. Physician's Office Services		
Covered Health Services for preventive medical care.	\$15 per visit. No Copayment applies when a Physician charge is not assessed.	No Benefits for preventive care, except Child Health Supervision Services.
Covered Health Services for the diagnosis and treatment of a Sickness or Injury received in a Physician's office.	\$15 per visit. No Copayment applies when a Physician charge is not assessed.	40% of Eligible Expenses
13. Professional Fees for Surgical and Medical Services	20% of Eligible Expenses	40% of Eligible Expenses

YOUR BENEFITS

Types of Coverage	Network Benefits / Copayment Amounts	Non-Network Benefits / Copayment Amounts
14. Prosthetic Devices Network and Non-Network Benefits for prosthetic devices are limited to \$2,500 per calendar year.	20% of Eligible Expenses	40% of Eligible Expenses
15. Reconstructive Procedures	Same as 8, 11, 12, 13 and 14	*Same as 8, 11, 12, 13 and 14
16. Rehabilitation Services - Outpatient Therapy Network and Non-Network Benefits are limited as follows: 20 visits of physical therapy; 20 visits of occupational therapy; 20 visits of speech therapy; 20 visits of pulmonary rehabilitation; and 36 visits of cardiac rehabilitation per calendar year.	\$15 per visit	40% of Eligible Expenses
17. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Network and Non-Network Benefits are limited to 60 days per calendar year.	20% of Eligible Expenses	*40% of Eligible Expenses
18. Transplantation Services	*20% of Eligible Expenses	*40% of Eligible Expenses
19. Urgent Care Center Services	\$50 per visit	40% of Eligible Expenses

Additional Benefits

Bones or Joints of the Jaw and Facial Region	Same as 8, 11, 12 and 13	*40% of Eligible Expenses
Child Health Supervision Services Coverage from birth to age 16.	Same as 11, 12, 13 and 16 No Annual Deductible applies.	Same as 11, 12, 13 and 16 No Annual Deductible applies.
Cleft Lip/Cleft Palate Treatment	Same as 8, 11, 12, 13, and 16	*40% of Eligible Expenses
Dental Procedures - Anesthesia and Hospitalization	Same as 8, 11, and 13	*Same as 8, 11 and 13
Diabetes Treatment	Same as 3, 11, 12 and 13	Same as 3, 11, 12 and 13
Mammography	No Copayment	Same as Network Benefit
Mastectomy	Same as 8, 11, 12 and 13	*Same as 8, 11, 12 and 13
Mental Health and Substance Abuse Services - Outpatient Must receive prior authorization through the Mental Health/Substance Abuse Designee. Network and Non-Network Benefits are limited to 30 visits per calendar year.	\$15 per individual visit; \$10 per group visit.	40% of Eligible Expenses
Mental Health and Substance Abuse Services - Inpatient and Intermediate Must receive prior authorization through the Mental Health/Substance Abuse Designee. Network and Non-Network Benefits are limited to 30 days per calendar year.	20% of Eligible Expenses	40% of Eligible Expenses
Osteoporosis Treatment	Same as 11, 12 and 13	Same as 11, 12 and 13
Prescription and Non-Prescription Enteral Formulas Benefits for low protein food products for Covered Persons through age 24 are limited to \$2,500 per calendar year.	20% of Eligible Expenses	40% of Eligible Expenses
Spinal Treatment Benefits include diagnosis and related services and are limited to one visit and treatment per day. Network and Non-Network Benefits are limited to 24 visits per calendar year.	\$15 per visit	40% of Eligible Expenses

Except as may be specifically provided in Section 1 of the Certificate of Coverage (COC) or through a Rider to the Policy, the following are not covered:

A. Alternative Treatments

Acupressure; hypnosis; rolfing; massage therapy; aromatherapy; acupuncture; and other forms of alternative treatment.

B. Comfort or Convenience

Personal comfort or convenience items or services such as television; telephone; barber or beauty service; guest service; supplies, equipment and similar incidental services and supplies for personal comfort including air conditioners, air purifiers and filters, batteries and battery chargers, dehumidifiers and humidifiers; devices or computers to assist in communication and speech.

C. Dental

Except as specifically described as covered in Section 1 of the COC under the headings Dental Services - Accident only, Dental Services - Anesthesia and Hospitalization and Cleft Lip/Cleft Palate Treatment, dental services are excluded. There is no coverage for services provided for the prevention, diagnosis, and treatment of the teeth or gums (including extraction, restoration, and replacement of teeth and services to improve dental clinical outcomes). Dental implants and dental braces are excluded. Dental x-rays, supplies and appliances and all associated expenses arising out of such dental services (including hospitalizations and anesthesia) are excluded, except as might otherwise be required for transplant preparation, initiation of immunosuppressives, the direct treatment of acute traumatic Injury, cancer, or cleft palate, or as described in Section 1 of the COC under the heading of Dental Procedures - Anesthesia and Hospitalization. Treatment for congenitally missing, malpositioned, or super numerary teeth is excluded, even if part of a Congenital Anomaly except in connection with cleft lip or cleft palate except as described in Section 1 of the COC under the heading Cleft Lip/Cleft Palate Treatment.

D. Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill. Self-injectable medications except as described in Section 1 of the COC under the heading of Diabetes Treatment. Non-injectable medications given in a Physician's office except as required in an Emergency. Over-the-counter drugs and treatments.

E. Experimental, Investigational or Unproven Services

Experimental, Investigational or Unproven Services are excluded, except (a) bone marrow transplants and (b) medically appropriate medications prescribed for the treatment of cancer, for a particular indication, if that drug is recognized for the treatment of that indication in a standard reference compendium or recommended in medical literature. The fact that an Experimental, 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, Investigational or Unproven in the treatment of that particular condition.

F. Foot Care

Routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting, or debriding; hygienic and preventive maintenance foot care; treatment of flat feet or subluxation of the foot; shoe orthotics.

G. Medical Supplies and Appliances

Devices used specifically as safety items or to affect performance primarily in sports-related activities. Prescribed or non-prescribed medical supplies and disposable supplies including but not limited to elastic stockings, ace bandages, gauze and dressings, ostomy supplies, syringes and diabetic test strips. Orthotic appliances that straighten or re-shape a body part (including cranial banding and some types of braces). Tubings and masks are not covered except when used with Durable Medical Equipment as described in Section 1 of the COC.

H. Mental Health/Substance Abuse

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment, or crisis intervention. Mental Health treatment of insomnia and other sleep disorders, neurological disorders, and other disorders with a known physical basis.

Treatment of conduct and impulse control disorders, personality disorders, paraphilias and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Abuse Designee.

Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclozocine, or their equivalents. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Mental Health/Substance Abuse Designee. Residential treatment services. Services or supplies that in the reasonable judgment of the Mental Health/Substance Abuse Designee are not, for example, consistent with certain national standards or professional research further described in Section 2 of the COC.

I. Nutrition

Megavitamin and nutrition based therapy; nutritional counseling for either individuals or groups. Enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk, except as described in Section 1 of the COC under the heading Prescription and Non-prescription Enteral Formulas.

J. Physical Appearance

Cosmetic Procedures including, but not limited to, pharmacological regimens; nutritional procedures or treatments; salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, and/or which are performed as a treatment for acne. Replacement of an existing breast implant is excluded if the earlier breast implant was a Cosmetic Procedure. (Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy.) Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation. Weight loss programs for medical and non-medical reasons. Wigs, regardless of the reason for the hair loss.

K. Providers

Services performed by a provider with your same legal residence or who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider as further described in Section 2 of the COC (this exclusion does not apply to mammography testing).

L. Reproduction

Health services and associated expenses for infertility treatments. Surrogate parenting. The reversal of voluntary sterilization.

M. Services Provided under Another Plan

Health services for which coverage is paid under arrangements required by federal, state or local law. This includes, but is not limited to, coverage paid by workers' compensation, no-fault automobile insurance or similar legislation. 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.

N. Transplants

Health services for organ or tissue transplants are excluded, except those specified as covered in Section 1 of the COC. Any solid organ transplant that is performed as a treatment for cancer. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. Health services for transplants involving mechanical or animal organs. Any multiple organ transplant not listed as a Covered Health Service in Section 1 of the COC.

O. 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 transplantation services may be reimbursed at our discretion.

P. Vision and Hearing

Purchase cost of eye glasses, contact lenses, or hearing aids. Fitting charge for hearing aids, eye glasses or contact lenses. Eye exercise therapy. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.

Q. Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service - see definition in Section 10 of the COC.

Physical, psychiatric or psychological examinations, testing, vaccinations, immunizations or treatments otherwise covered under the Policy, when such services are: (1) required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption; (2) relating to judicial or administrative proceedings or orders; (3) conducted for purposes of medical research; or (4) 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, including health services for medical conditions arising prior to the date your coverage under the Policy ends.

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. In the event that a Non-Network provider waives Copayments and/or the Annual Deductible for a particular health service, no Benefits are provided for the health service for which Copayments and/or the Annual Deductible are waived.

Charges in excess of Eligible Expenses or in excess of any specified limitation.

Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature, except as described in Section 1 of the COC under the heading Bones or Joints of the Jaw and Facial Region. Upper and lower jaw bone surgery except as required for the direct treatment of acute traumatic Injury or cancer. Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint, except as a treatment of obstructive sleep apnea.

Surgical treatment and non-surgical treatment of obesity (including morbid obesity).

Growth hormone therapy; sex transformation operations; treatment of benign gynecomastia (abnormal breast enlargement in males); medical and surgical treatment of excessive sweating (hyperhidrosis); medical and surgical treatment for snoring, except when provided as part of treatment for documented obstructive sleep apnea. Oral appliances for snoring. Custodial care; domiciliary care; private duty nursing; respite care; rest cures.

Psychosurgery. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cleft lip/cleft palate or Congenital Anomaly.