



# Benefit Summary

Rhode Island - HEALTHpact Plan

10/750/90% Plan 38Y

## UnitedHealthcare Pledge Plan<sup>sm</sup>

We 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:

- Check personalized data: Find individualized information on your benefit coverage, check the status of claims, and search for physicians and hospitals using [www.myuhc.com](http://www.myuhc.com)®.
- Researching health information: Find resources by calling Care24<sup>sm</sup> or NurseLine® or by logging on to [www.myuhc.com](http://www.myuhc.com).
- Get help: Contact Customer Care at the telephone number on the back of your ID card when you need assistance locating physicians and other health care professionals in your network or when you have coverage or benefit questions.

### PLAN HIGHLIGHTS: ADVANTAGE LEVEL

#### Types of Coverage Network Benefits

##### Annual Deductible

Individual Deductible	\$750 per year
Family Deductible	\$1,500 per year

> Member Copayments do not accumulate towards the Deductible.

##### Out-of-Pocket Maximum

Individual Out-of-Pocket Maximum	\$2,000 per year
Family Out-of-Pocket Maximum	\$4,000 per year

> The Out-of-Pocket Maximum does not include the Annual Deductible.

> Member Copayments do not accumulate towards the Out-of-Pocket Maximum.

##### Benefit Plan Coinsurance - The Amount We Pay

90% after Deductible has been met

##### Maximum Policy Benefit

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

##### Prescription Drug Benefits

Prescription drug benefits are shown under separate cover.

This Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary conflicts in any way with the Certificate of Coverage (COC), the COC shall prevail. It is recommended that you review your COC for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

**RIWAJ38Y07**

<b>Item#</b>	<b>Rev. Date</b>	<b>Benefit Accumulator</b>
525-3093	0807	Policy Year

UnitedHealthcare of New England, Inc. and UnitedHealthcare Insurance Company

## Information on Benefit Limits

- > The Annual Deductible, Out-of-Pocket Maximum and Benefit limits are calculated on a Policy year basis.
- > All Benefits are reimbursed based on Eligible Expenses. For a definition of Eligible Expenses, please refer to your Certificate of Coverage.

## MOST COMMONLY USED BENEFITS

Types of Coverage	Network Benefits
<b>Physician's Office Services - Sickness and Injury</b>	
Primary Physician Office Visit	100% after you pay a \$10 Copayment per visit. The Primary Physician Copayments are waived for annual physical exams received in accordance with the guidelines established by the American Medical Association.
Specialist Physician Office Visit	100% after you pay a \$50 Copayment per visit.
<b>Preventive Care Services</b>	
Covered Health Services include but are not limited to:	
Primary Physician Office Visit	100% after you pay a \$10 Copayment per visit. The Primary Physician Copayments are waived for annual physical exams received in accordance with the guidelines established by the American Medical Association. Preventive immunizations received from a Primary Physician are covered at 100% and do not require a Copayment.
Specialist Physician Office Visit	100% after you pay a \$50 Copayment per visit.
Lab, X-Ray or other preventive tests	Mammograms, Pap Tests and PSA Tests: 100% Deductible does not apply. All other: 90% after Deductible has been met
<b>Urgent Care Center Services</b>	
	100% after you pay a \$100 Copayment per visit. If you are admitted as an inpatient to a Network Hospital directly from the Urgent Care Center, you will not have to pay this Copayment. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.
<b>Emergency Health Services - Outpatient</b>	
	100% after you pay a \$200 Copayment per visit. If you are admitted as an inpatient to a Network Hospital directly from the Emergency room, you will not have to pay this Copayment. The Benefits for an Inpatient Stay in a Network Hospital will apply instead. <i>Pre-service Notification is required if results in an Inpatient Stay.</i>
<b>Hospital - Inpatient Stay</b>	
	90% after Deductible has been met.

## ADDITIONAL CORE BENEFITS

Types of Coverage	Network Benefits
<b>Ambulance Service - Emergency and Non-Emergency</b>	
Ground Ambulance	80% Deductible does not apply
Air Ambulance	80% Deductible does not apply
	<i>Pre-service Notification is required for Non-Emergency Ambulance.</i>
<b>Congenital Heart Disease (CHD) Surgeries</b>	
	90% after Deductible has been met.
	<i>Pre-service Notification is required.</i>
<b>Dental Services - Accident Only</b>	
Benefits are limited as follows: \$3,000 maximum per year \$900 maximum per tooth	90% after Deductible has been met.
	<i>Pre-service Notification is required.</i>
<b>Diabetes Services</b>	
Diabetes Self Management and Training Diabetic Eye Examinations/Foot Care	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.
Diabetes Self Management Items	80% after Deductible has been met
<b>Durable Medical Equipment</b>	
Benefits are limited as follows: \$2,500 per year and are limited to a single purchase of a type of Durable Medical Equipment (including repair and replacement) every three years.	Outpatient: 80% after Deductible has been met Inpatient: 90% after Deductible has been met.
<b>Home Health Care</b>	
Benefits are limited as follows: 60 visits per year	90% after Deductible has been met.
<b>Hospice Care</b>	
	90% after Deductible has been met.

## ADDITIONAL CORE BENEFITS

<b>Types of Coverage</b>	<b>Network Benefits</b>
<b>Lab, X-Ray and Diagnostics - Outpatient</b>	
For Preventive Lab, X-Ray and Diagnostics, refer to the Preventive Care Services category.	90% after Deductible has been met
<b>Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient</b>	
	90% after Deductible has been met.
<b>Ostomy Supplies</b>	
Benefits are limited as follows: \$2,500 per year	Outpatient: 80% after Deductible has been met Inpatient: 90% after Deductible has been met.
<b>Pharmaceutical Products - Outpatient</b>	
This includes medications administered in an outpatient setting, in the Physician's Office and by a Home Health Agency.	90% after Deductible has been met.
<b>Physician Fees for Surgical and Medical Services</b>	
	90% after Deductible has been met.
<b>Pregnancy - Maternity Services</b>	
	90% after Deductible has been met
<b>Prosthetic Devices</b>	
Benefits are limited as follows: \$2,500 per year and are limited to a single purchase of each type of prosthetic device every three years.	Outpatient: 80% after Deductible has been met Inpatient: 90% after Deductible has been met.
<b>Reconstructive Procedures</b>	
	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.
<b>Rehabilitation Services - Outpatient Therapy</b>	
Benefits are limited as follows: 20 visits of physical, occupational, and speech therapy combined 20 visits of pulmonary rehabilitation 20 visits of cardiac rehabilitation	100% after you pay a \$50 Copayment per visit.

## ADDITIONAL CORE BENEFITS

Types of Coverage	Network Benefits
<b>Scopic Procedures - Outpatient Diagnostic and Therapeutic</b>	
<p>Diagnostic scopic procedures include, but are not limited to:</p> <ul style="list-style-type: none"> <li>Colonoscopy</li> <li>Sigmoidoscopy</li> <li>Endoscopy</li> </ul> <p>For Preventive Scopic Procedures, refer to the Preventive Care Services category.</p>	90% after Deductible has been met.
<b>Skilled Nursing Facility / Inpatient Rehabilitation Facility Services</b>	
<p>Benefits are limited as follows:</p> <ul style="list-style-type: none"> <li>100 days per year</li> </ul>	90% after Deductible has been met
<b>Surgery - Outpatient</b>	
	90% after Deductible has been met.
<b>Therapeutic Treatments - Outpatient</b>	
<p>Therapeutic treatments include, but are not limited to:</p> <ul style="list-style-type: none"> <li>Dialysis</li> <li>Intravenous chemotherapy or other intravenous infusion therapy</li> <li>Radiation oncology</li> </ul>	90% after Deductible has been met
<b>Transplantation Services</b>	
	90% after Deductible has been met.
	<p>For Benefits, services must be received at a Designated Facility.  <i>Pre-service Notification is required.</i></p>

## STATE MANDATED BENEFITS

### Types of Coverage

### Network Benefits

#### Clinical Trials-Cancer Therapies

Participation in a qualifying clinical trial for the treatment of:  
Cancer

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.

*Pre-service Notification is required.*

#### Early Intervention Services

Benefits are limited as follows:  
\$5,000 per year.  
This limit does not apply toward the Maximum Policy Benefit, if applicable.

100% Deductible does not apply.

#### Hearing Aids

Benefits are limited as follows:  
\$1,500 per individual hearing aid, per ear for a single purchase of a hearing aid every three years for Covered Persons under the age of nineteen (19) years.  
\$700 per individual hearing aid, per ear for a single purchase of a hearing aid every three years for Covered Persons nineteen (19) years of age or older.

80% after Deductible has been met.

#### Infertility Services

Benefits are limited as follows:  
\$100,000 per lifetime.

80% after Deductible has been met.

*Pre-service notification is required.*

#### Lyme Disease

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.

#### Mental Health and Substance Abuse (MH/SA) Services - Inpatient and Intermediate

Benefits are limited as follows:  
30 days per year for community residential care services for Substance Abuse treatment.  
5 detoxification occurrences or 30 days per year, whichever comes first, for Substance Abuse Services for detoxification.

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.

*Prior Authorization is required from the MH/SA Designee.*

### Mental Health and Substance Abuse (MH/SA) Services - Outpatient

Benefits are limited as follows:

30 visits per year for Mental Health Services.

30 hours per year for Substance Abuse Services.

Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.

*Prior Authorization is required from the MH/SA Designee.*

### Mental Health Services - Outpatient Child and Family Intensive Treatment

Benefits are limited as follows:

6 hours per week to a maximum of 10 weeks per year. One week of treatment, regardless of the number of hours, equals 1 visit.

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.

*Prior Authorization is required from the MH/SA Designee.*

### Orthotic Devices

Benefits are limited as follows:

\$2,500 in Eligible Expenses per year. Benefits are limited to a single purchase of a type of orthotic device (including repair/replacement) every three years.

90% after Deductible has been met.

You must purchase or rent the orthotic device from the vendor we identify or purchase it directly from the prescribing Network Physician.

### Tobacco Cessation Treatment - Outpatient

Benefits are limited as follows:

Eight (30-minute) Tobacco Cessation counseling sessions each year.

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.

### Wigs

Benefits are limited as follows:

\$350 per year.

100% Deductible does not apply.

This Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary conflicts in any way with the Certificate of Coverage (COC), the COC shall prevail. It is recommended that you review your COC for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

## MEDICAL EXCLUSIONS CONTINUED

### MEDICAL EXCLUSIONS

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

#### Alternative Treatments

Acupressure; acupuncture; aromatherapy; hypnotism; massage therapy; rolfing; art, 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 osteopathic care for which Benefits are provided as described in Section 1 of the COC.

#### Dental

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

#### Devices and Appliances

Devices used specifically as safety items or to affect performance in sports-related activities. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics, cranial banding and some types of braces, including over-the-counter orthotic braces. This exclusion does not apply to Covered Health Services as described under Orthotic Devices in Section 1 of the COC. The following items are excluded, even if prescribed by a Physician: blood pressure cuff/monitor; enuresis alarm; home coagulation testing equipment; non-wearable external defibrillator; trusses; ultrasonic nebulizers; and ventricular assist devices. Devices and computers to assist in communication and speech except for speech aid prosthetics and tracheo-esophageal voice prosthetics. Oral appliances for snoring. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect.

Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

#### Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office. Over-the-counter drugs and treatments. Growth hormone therapy.

#### Experimental, Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials - Cancer Therapies in Section 1 of the COC.

#### Foot Care

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

#### Medical Supplies

Prescribed or non-prescribed medical supplies and disposable supplies. Examples include: elastic stockings, ace bandages, gauze and dressings, urinary catheters. This exclusion does not apply to:

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

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

## MEDICAL EXCLUSIONS CONTINUED

### Mental Health / Substance Abuse

Services performed in connection with conditions not classified in the current edition of either the Diagnostic and Statistical Manual of the American Psychiatric Association or the International Classification of Disease Manual (ICD) published by the World Health Organization. Treatment for mental retardation, learning disorders, motor skills disorders, communication disorders and mental disorders classified as "V" codes. Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents. Residential treatment services except as provided for Substance Abuse Services as described under Mental Health and Substance Abuse Services - Inpatient and Intermediate in Section 1 of the COC. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance abuse disorders that, in the reasonable judgment of the Mental Health/Substance Abuse Designee, are not medically necessary.

### Nutrition

Individual and group nutritional counseling, except as described under Diabetes Services in Section 1 of the COC. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:

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

Please Note: In order to receive the Advantage Plan level of benefits and reduce your cost shares, you must comply with the wellness requirements, including disease management, that are outlined in the Introduction to Your Certificate Section. If you do not meet these requirements you will be enrolled in the Basic Plan and will be responsible for higher levels of cost sharing. Enteral feedings, even if the sole source of nutrition. Infant formula and donor breast milk. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods).

### Personal Care, Comfort or Convenience

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

### Physical Appearance

Cosmetic Procedures. See the definition in Section 9 of the COC. Examples include: pharmacological regimens, nutritional procedures or treatments. Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). Skin abrasion procedures performed as a treatment for acne. Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. Treatment for skin wrinkles or any treatment to improve the appearance of the skin. Treatment for spider veins. Hair removal or replacement by any means. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See Reconstructive Procedures in Section 1 of the COC. Treatment of benign gynecomastia (abnormal breast enlargement in males). Breast reduction except as coverage is required by the Women's Health and Cancer Right's Act of 1998 for which Benefits are described under Reconstructive Procedures in Section 1 of the COC. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation. Wigs regardless of the reason for the hair loss, except for scalp hair prosthesis as described under Wigs in Section 1 of the COC.

### Procedures and Treatments

Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, and brachioplasty. Medical and surgical treatment of excessive sweating (hyperhidrosis). Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, or autism spectrum disorders. Psychosurgery. Sex transformation operations. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter. Biofeedback. Chiropractic treatment (the therapeutic application of chiropractic 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 medical or dental in nature. Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury, dislocation, tumors or cancer. Orthognathic surgery, jaw alignment and treatment for the temporomandibular joint, except as a treatment of obstructive sleep apnea. Surgical and non-surgical treatment of obesity.

### Providers

Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. Services performed by a provider with your same legal residence. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-

based diagnostic facility, when that Physician or other provider has not been actively involved in your medical care prior to

ordering the service, or is not actively involved in your medical care after the service is received. This exclusion does not apply to mammography. Foreign language and sign language interpreters. Services performed by a Non-Network Provider are not covered for the Advantage and Basic Plans, with the exception of those services as described in Section 5 of the COC.

### Reproduction

The following infertility treatment-related services: Cryo-preservation and other forms of preservation of reproductive materials, long-term storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue, testicular tissue, and donor services. Surrogate parenting, donor eggs, donor sperm and host uterus. The reversal of voluntary sterilization. Maternity related medical services for Enrolled Dependent children.

### Services Provided under Another Plan

Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation. If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness, or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.

### Transplants

Health services for organ and tissue transplants, except those described under Transplantation Services in Section 1 of the COC. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.) Health services for transplants involving permanent mechanical or animal organs. Transplant services that are not performed at a Designated Facility. This exclusion does not apply to cornea transplants.

### Travel

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

### Types of Care

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

to return a person to work or to prepare a person for specific work).

### Vision

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

### All Other Exclusions

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

UnitedHealthcare of New England, Inc. and UnitedHealthcare Insurance Company