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BlueCross BlueShield
of Mississippi

Benefit Choice

Benefit Choice
Certificate of Coverage

This Certificate of Coverage provides basic information regarding benefits provided to individuals with Benefit Choice coverage, as well as benefit limitations and services that are not covered. The Certificate of Coverage is an example of the most popular Benefit Choice benefit option and is not a guarantee of coverage for a particular benefit. Following enrollment, covered members will be able to view their detailed Benefit Booklet through the *my*Blue Member portal.

Schedule of Benefits

Benefit Choice

Benefit Plan Year

A period of one calendar year commencing each January 1 through December 31.

Lifetime Maximum Benefits

Unlimited

Deductible Amounts

Individual Medical Deductible	**$500**
Family Maximum Deductible	**$1,000**
Non-Network Individual Medical Deductible	**$1,000**
Non-Network Family Medical Deductible	**$2,000**
Prescription Drug Deductible Individual	**$100**

The Deductible Amounts listed above are separate and distinct. These Deductible Amounts are not interchangeable. The Network Medical and Prescription Drug Deductibles do not apply where there is a Co-payment amount, except in the case of Category 2, 3, and 4 Prescription Drugs and the Non-Emergency Room Co-payment. If the Member is referred by the Network Provider to another Network or Non-Network Provider for additional services including, but not limited to, laboratory or diagnostic services, the applicable Network or Non-Network Deductible will apply, dependent upon the place of treatment. Network Co-payment amounts do not accrue toward the Network Deductible Amounts but do accrue to the Out-of-Pocket Maximum.

The Member must satisfy the Network Medical Deductible and Prescription Drug Deductible prior to Benefits being paid for Covered Services rendered by a Network Provider.

The Member must satisfy the Non-Network Medical Deductible prior to Benefits being paid for Covered Services rendered by a Non-Network Provider.

Out-of-Pocket Maximum

Network Provider

Individual Out-of-pocket	**$5,000**
Family Out-of-pocket	**$10,000**

When a Subscriber's or Dependent's Out-of-pocket expenses for Deductibles, Co-payments and Co-insurance for Covered Services rendered by Network Providers reach the Out-of-pocket amount during a Calendar Year, Allowable for Covered Services rendered by Network Providers will be paid at 100% (where applicable) for the remainder of the Calendar Year.

The Member's Out-of-pocket expenses for the Non-Network Medical Deductible amount and Co-insurance for Covered Services rendered by Non-Network Providers will not be applied to the Out-of-pocket amount. Allowable for Covered Services rendered by a Non-Network Provider will not be paid at 100% of the Allowable after the Out-of-pocket has been satisfied.

Blue Primary Care Home

Through a Blue Primary Care Home, the Member will establish a relationship with their Blue Primary Care Network Provider who will provide coordinated and continuing care. The Member should designate a Blue Primary Care Network Provider located and practicing in Mississippi who is accepting patients and who will provide their *Healthy You!* visit and Color Me Healthy! Covered Services, if applicable. If the Member does not designate a Blue Primary Care Network Provider, the Company may designate one for the Member. The Blue Primary Care Home designation is for Members 18 years and older.

Members who reside outside of Mississippi should select a Primary Care Home Network Provider located and practicing in their state of residence, where available.

Referral by a Blue Primary Care Network Provider is not needed for obstetrical or gynecological care by a Network Provider specializing in obstetrics or gynecology. However, the obstetrician/gynecologist may be required to comply with certain procedures, including obtaining Prior Authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

For information on how to select a Blue Primary Care Network Provider, and for a list of Blue Primary Care Network Providers, please use the Network Provider search tool located on Company's website at www.bcbsms.com or contact our Customer Service Team at 601-664-4590 or 800-942-0278.

Benefits

The Member must designate a *Healthy You!* or Blue Primary Care Network Provider who is a Network Provider located and practicing in the State of Mississippi and who is accepting patients.

Company will provide Benefits for Covered Services as specified below. Benefits are based on the Allowable minus: (1) any applicable Deductible Amount, (2) any applicable Co-payment, and/or (3) any applicable Co-insurance.

All Covered Services are subject to Care Management. Certain Benefits will only be provided when the Member receives Covered Services from Network Providers that are designated by the Company as a Center of Excellence or as a Network Provider privileged/credentialed and approved by the Company for the Covered Services.

OUT-OF-STATE NON-EMERGENT ELECTIVE SERVICES FROM A NETWORK PROVIDER MUST BE PRIOR APPROVED BY THE COMPANY TO RECEIVE BENEFITS. BENEFITS FOR NON-EMERGENT ELECTIVE SERVICES FROM AN OUT-OF-STATE NETWORK PROVIDER ARE NOT AVAILABLE IF THE ELECTIVE SERVICES ARE REASONABLY AVAILABLE THROUGH AN IN-STATE NETWORK PROVIDER. BENEFITS FOR OUT-OF-STATE NON-EMERGENT ELECTIVE SERVICES ARE NOT AVAILABLE WHEN PROVIDED BY OUT-OF-STATE NON-NETWORK PROVIDERS. OUT-OF-STATE RESIDENTS WILL NOT BE REQUIRED TO RECEIVE PRIOR AUTHORIZATION FOR OUT-OF-STATE NON-EMERGENT ELECTIVE SERVICES.

Covered Services	Benefit	
	Blue Primary Care Network Provider or *Healthy You!* Network Provider	**Non-Network Provider**
***Healthy You!* Preventive Health Services**	**100%** (Deductible Waived)	**Not Covered**

Outpatient Services, based on age/sex parameters, must be rendered by a *Healthy You!* Network Provider designated by the Company who is a Network Provider located and practicing in Mississippi and who is accepting patients. Members who reside outside of Mississippi should select a Network Provider located and practicing in their state of residence. Services must be provided in that Provider's clinical setting. See the *Healthy You!* Preventive Health Services Age and Gender Guidelines located on *my*Blue® for the Covered Services.

	Color Me Healthy! Network Provider	**Non-Network Provider**
Color Me Healthy!	**100%**	**Not Covered**

Outpatient Services rendered by a Color Me Healthy! Network Provider designated by the Company when the Member is enrolled in the Color Me Healthy! Benefit that focuses on the treatment and control of metabolic health risks and diseases as defined by the Company.

Members with a Blue Primary Care Home will receive *Healthy You!* and Color Me Healthy! Covered Services from their selected Blue Primary Care Network Provider.

Center of Excellence Specialty Services

(See a listing of the BCBSMS Centers of Excellence and Specialty Services located on the secure *my*Blue Member portal at www.bcbsms.com)

	Center of Excellence Provider	Specialty Care Designated Network Provider	Non-Specialty Care Designated Provider
Inpatient Services	**90%**	**70%**	**Not Covered**
Outpatient Services	**90%**	**70%**	**Not Covered**
Physician Surgeon Services	**90%**	**70%**	**Not Covered**

When a Member receives Specialty Services at a Center of Excellence Network Provider, only the Network facility and the Network Physician surgeon performing the covered Specialty Service will be paid at the higher co-insurance level.

OTHER NETWORK PROFESSIONAL COVERED SERVICES TO INCLUDE ANESTHESIA WILL BE PAID AT THE NETWORK PROVIDER CO-INSURANCE LEVEL.

SPECIALTY SERVICES include treatment and care related to the following inpatient hospital, outpatient hospital, and office setting services:

A. Cardiac Care – including, but not limited to, non-emergent cardiac percutaneous coronary interventions, coronary artery bypass graft surgery, and cardiac valve replacement;

B. Spine Surgery – including, but not limited to, discectomy, spinal fusion, and spinal decompression procedures;

C. Orthopedic Services – including, but not limited to, knee and hip replacement; and

D. Other Specialty Services as defined by the Company.

Specialty Services do not include Maternity Services regardless of whether the services are provided by a Network Provider designated as a Center of Excellence.

When a Member receives a Specialty Service in a Specialty Service Area with no designated Center of Excellence, the Center of Excellence section will not apply and services will be considered under the Hospital or Physicians Services sections set out below.

ALL SPECIALTY SERVICES ARE SUBJECT TO PRE-CERTIFICATION OR PRIOR AUTHORIZATION FOR MEDICAL NECESSITY OF THE COVERED SERVICES AND APPROPRIATENESS OF THE INPATIENT OR OUTPATIENT SETTING. SPECIALTY SERVICES ARE ONLY COVERED WHEN PROVIDED BY A CENTER OF EXCELLENCE NETWORK PROVIDER OR A SPECIALTY CARE DESIGNATED NETWORK PROVIDER. NO BENEFITS WILL BE PROVIDED WITHOUT PRIOR AUTHORIZATION.

	Network Provider	Non-Network Provider
Hospital Services (HOSPITAL SERVICES are those services that are not included under the Center of Excellence Network or Specialty Services.)		

All Hospital Admissions (to include Emergency, Nervous/Mental, and Substance Use Disorder Admissions) must be pre-certified as outlined in Article XIII, Care Management.

Inpatient Hospital Services	**80%**	**50%**
Other Services	**80%**	**50%**
Maternity Benefits (Limited to Benefits described in Article VII)	**80%**	**50%**
Inpatient Rehabilitation Services (Limited to 30 Inpatient days per Calendar Year)	**80%**	**Not Covered**
Outpatient Hospital Services	**80%**	**50%**

(Only certain Covered Services will be covered in an Outpatient Hospital Setting. Company may require a Prior Authorization for Outpatient Hospital Services if the Covered Service can be provided in a lower place of treatment (i.e. Ambulatory Surgical Facility, Center of Excellence, or office.)

Emergency Room Services
(Professional Services are included)
(Deductible Applies)

Emergency	**80%**	**80%**
Non-Emergency	**80%** **after $350 Co-pay**	**50%** **after $350 Co-pay**

When the Member obtains Emergency Room Services from a Network Provider (Hospital) or Non-Network Provider (Hospital) in the case of Nervous/Mental Conditions or Substance Use Disorders, Covered Services will be subject to the Medical Emergency Benefit. Network Benefits will be applied subject to the Member satisfying the Benefit Period Deductible Amount.

	Network Provider	Non-Network Provider
Ambulatory Surgical Facility Services (ASF)	**80%**	**50%**

		Network Provider	Non-Network Provider
Physician Services (M.D. and D.O. only)	**Primary Care**	**Specialist**	
Office Visits (The Co-pay does not apply to any Other Services rendered in the Physician's Office.)	**$25 Co-pay** (Family Practice, General Practice, Internal Medicine, Pediatricians, and OB/GYN)	**$40 Co-pay**	**50%**
Other Office Services rendered in the Physician's Office (The term "Services" does not include Durable Medical Equipment, Prosthetics or Orthotic Devices.) (Deductible does not apply to services rendered in a Network Physician's Office.)		**80%**	**50%**
Other Physician Services		**80%**	**50%**

	Network Provider	Non-Network Provider
Newborn Well Baby Care (Subsequent visits, circumcision and discharge of baby)	**80%**	**50%**

Other Covered Services	Benefit	
	Network Provider	**Non-Network Provider**
Allied Primary Care Health Professional		
Office Visits (The Co-pay does not apply to any Other Services rendered in the office.)	**$25 Co-pay**	**50%**
Other Services rendered in the Office (Deductible does not apply to services rendered in a Network Provider's office)	**80%**	**50%**

	Network Provider	**Non-Network Provider**
Allied Specialist		
Office Visits (The Co-pay does not apply to any Other Services rendered in the office.)	**$40 Co-pay**	**50%**
Other Services rendered in the Office (Deductible does not apply to services rendered in a Network Provider's office)	**80%**	**50%**
Other Allied Primary Care and Specialist Provider Services	**80%**	**50%**

When Physical Medicine Services are provided, Benefits will be limited to 20 visits per Calendar Year, subject to Medical Necessity, and three (3) modalities per visit. Visit limits apply to Physical Medicine visits in the home and at the Allied Specialist's office or facility. No Benefits will be provided for Physical Medicine services provided by a Non-Network Provider.

Ambulance Services	**80%**	**50%**
Allergy Injections/Testing Services	**80%**	**50%**
Diagnostic Services Facility	**80%**	**Not Covered**
Dialysis Treatment	**80%**	**Not Covered**
Durable Medical Equipment (Medical Necessity Certificate Required)	**80%**	**Not Covered**

	Network Provider	Non-Network Provider
Habilitative Care (Limited to 20 Physical Therapy and Occupational Therapy visits, combined, and 20 Speech Therapy visits per Calendar Year)	**80%**	**Not Covered**
Hospice Care (Limited to 6 months per the lifetime of the Member) (Subject to Care Management)	**80%**	**Not Covered**
Independent Laboratory	**80%**	**Not Covered**
Infusion Therapy (Subject to Care Management)	**80%**	**Not Covered**
Orthotic Devices (Medical Necessity Certificate Required)	**80%**	**80%**
Outpatient Cardiac Rehabilitation (Covered Services must be rendered by a Network Provider that is a Certified Facility) (Visit limits are based on the severity of patient's condition, not to exceed 36 visits)	**80%**	**Not Covered**
Physical Medicine (Limited to 20 visits per Calendar Year) (Limited to 3 Modalities per visit)	**80%**	**Not Covered**
Prosthetic Appliances (Medical Necessity Certificate Required)	**80%**	**80%**
Sleep Studies (Services must be rendered by a facility or home sleep study Network Provider accredited by AASM)	**80%**	**Not Covered**
Speech Therapy (Limited to 20 Rehabilitative Care visits per Calendar Year)	**80%**	**80%**
Therapy Services	**80%**	**Not Covered**

Prescription Drugs

No Benefits will be provided for any Prescription Drug not included in Company's Prescription Drug Formulary or Maintenance Drug Formulary. All Prescription Drug Benefits are subject to Care Management to include Prior Authorization which may be required prior to Benefits being provided, Medical Necessity and appropriateness of care.

Only those Prescription Drugs within the Maintenance Drug Formulary are eligible for a 90-day supply.

If a generic equivalent Prescription Drug is available, but the member purchases the brand name, the Member will be responsible for the entire cost of the drug. Benefits for Prescription Drugs are subject to Quantity Limits and/or day limits and Medical Policy. No Benefits will be provided for Prescription Drugs prescribed or dispensed beyond the Quantity Limits and/or day limits. Certain Prescription Drugs are subject to clinically appropriate duration of use restrictions based upon the usual course of treatment. Benefits may be reduced if the Member uses a drug manufacturer's coupon which reduces or eliminates the Member's liability.

As part of Generic First, certain Prescription Drugs that have a generic or lower cost alternative may be subject to a trial usage of the generic alternative drug for a specific period of time before Benefits will be available for the prescribed drug.

Subject to Prior Authorization, Benefits may be available for Category Four Prescription Drugs where a lower cost alternative is available. If Benefits are provided, the Benefits will be no greater than the Benefit for the lowest cost alternative.

The Prescription Drug Deductible (if applicable) only applies to those drugs that are in Categories Two, Three or Four.

	Community PLUS Pharmacy	Non-Community PLUS Pharmacy
Prescription Drugs (Limited to a 30-day supply)		
Category One Drugs	**100% after $10 Co-pay**	**Not Covered**
Category Two Drugs	**100% after $25 Co-pay**	**Not Covered**
Category Three Drugs	**100% after $50 Co-pay**	**Not Covered**
Category Four Drugs	**100% after $100 Co-pay**	**Not Covered**

	Community PLUS Maintenance Pharmacy		Non-Maintenance Pharmacy
Maintenance Drugs (Limited to a 90-day supply)	**Generic**	**Brand**	
Category One Drugs	**100% after $25 Co-pay**	**100% after $30 Co-pay**	**Not Covered**
Category Two Drugs	**100% after $62.50 Co-pay**	**100% after $75 Co-pay**	**Not Covered**
Category Three Drugs	**100% after $125 Co-pay**	**100% after $150 Co-pay**	**Not Covered**
Category Four Drugs	**100% after $250 Co-pay**	**100% after $300 Co-pay**	**Not Covered**

	Network Provider	Non-Network Provider
Disease Specific Drugs (Drugs must be provided by a Network Disease Specific Pharmacy or a Member's Non-Pharmacy Network Provider; have been Prior Authorized by the Company; and listed in the Disease Specific Drug Formulary)	**100% after 10% of the Allowable up to $200 Co-pay with a minimum $100 Co-pay.**	**Not Covered**

No Benefits will be provided for any Disease Specific Drug not included in Company's Disease Specific Drug Formulary. Benefits will not be provided if the Member receives financial assistance from a drug manufacturer or if the Member has no obligation to pay for the Disease Specific Drug.

Nervous/Mental and Substance Use Disorder Benefits

All services are subject to Care Management, Medical Necessity and appropriateness of care.

	Network Provider	Non-Network Provider
Inpatient Care	**80%**	**50%**
Inpatient Rehabilitation Services	**80%**	**50%**
Residential Treatment Center	**80%**	**50%**
Partial Hospitalization	**80%**	**50%**
Outpatient Hospital Visits	**80%**	**50%**
Other Outpatient Physician and Allied Provider Services	**80%**	**50%**
Physician and Allied Provider Office Visits (Co-pay does not apply to any Other Services rendered in the Physician or Allied Provider's Office)	**$25 Co-pay**	**50%**
Other Services rendered in the Physician and Allied Provider's Office (Deductible does not apply to services rendered in a Network Physician or Allied Provider's Office.)	**80%**	**50%**

Organ and Tissue Transplant Benefits

Prior Authorization is required. No Benefits will be provided unless Network Provider receives Prior Authorization from Company.

	Network Provider	Non-Network Provider
Renal Transplants	**80%**	**Not Covered**
Other Solid Organ Transplants (Liver, Heart, Lung)	**80%**	**Not Covered**
Tissue Transplants (Bone Marrow Transplants)	**80%**	**Not Covered**
Donor Benefits	**100%**	**Not Covered**

Temporomandibular/Craniomandibular Joint Disorder (TMJ)

Prior Authorization is required. No Benefits will be provided unless Network Provider receives Prior Authorization from Company.

	Network Provider	Non-Network Provider
Surgery/Diagnostic Services and removable oral appliances for TMJ	**80%**	**Not Covered**

	Network Provider	Non-Network Provider
Diabetes Treatment		
Equipment, Supplies for the monitoring of blood glucose and insulin administration. (Home glucose monitors limited to 1 monitor every 2 years)	**80%**	**Not Covered**
Diabetes Self-Management Training (Limited to six (6) hours per Calendar Year)	**80%**	**Not Covered**
Dilated Eye Exam (Limited to one exam per Calendar Year)	**80%**	**Not Covered**
Preventive Routine Foot Care (Limited to one visit per Calendar Year)	**80%**	**Not Covered**

	Network Provider	Non-Network Provider
Other Preventive Health Services (Outpatient) (Based on Age/Sex Parameters)	**100%** (Deductible Waived)	**Not Covered**

Services must be rendered by a Network Provider approved by Company in that Provider's clinical setting. Covered Services must be included in the Grade A and B Recommendations of the United States Preventative Services Task Force. Covered Services also include all other preventive health services required by the Patient Protection and Affordable Care Act.

	Network Provider	Non-Network Provider
Pediatric Vision Services (Available only for Members under the age of 19) (Deductible does not apply)		
Routine Eye Exam	**$40 Co-pay**	**Not Covered**
Eyeglasses (One Pair per year, subject to limitations contained in this Benefit Plan)	**100%** **up to $150**	**Not Covered**

	Network Provider	Non-Network Provider
Pediatric Dental Services (Available only for Members under the age of 19) (Deductible does not apply)		
Preventive Dental Services (Preventive and Diagnostic Services)	**80%**	**80%**
Other Dental Services (As defined in this Benefit Plan)	**50%**	**50%**

Limitations and Exclusions

A. Benefits will not be provided for the following:

1. Incremental nursing charges which are in addition to the Hospital's standard charge for Inpatient Services.

2. The amount of charges for luxury accommodations or any accommodations in any Hospital or Allied Health Facility provided primarily for the patient's convenience which exceeds the Allowable for a standard Hospital room.

3. Bed and Board in any other room at the same time Benefits are provided for use of a Special Care Unit.

4. Any Prescription Drug not included in the Prescription Drug Formulary, Maintenance Drug Formulary or Disease Specific Drug Formulary.

5. Prescription Drugs that are determined by Company not to be Medically Necessary for the treatment of illness or injury. These drugs include but are not limited to the following:

   a. Drugs used for cosmetic purposes or weight reduction.

   b. Any drug not proven effective in general medical practice.

   c. Investigative drugs and drugs used other than for the FDA approved diagnosis except for drugs used in the treatment of cancer provided that such drug is recognized for treatment of the specific type of cancer for which the drug was prescribed in one of the standard reference compendia or in the medical literature.

   d. Fertility drugs.

   e. Minerals and vitamins (Exception: pre-natal vitamins).

   f. Nutritional supplements.

   g. Drugs that do not require a prescription.

   h. Contraceptive devices (Exception: prescription contraceptives including Birth Control Pills, Norplant, Depro Provera, Intrauterine Devices (IUD), Diaphragms, and Plan B as required by the Patient Protection and Affordable Care Act).

   i. Prescription Drugs if an equivalent product is available over the counter.

   j. Refills in excess of the number specified by the Physician or any refills dispensed more than one year after the date of Physician's original prescription.

   k. Certain brand name drugs that require trial usage of a generic alternative before Benefits are available for the brand name drug.

l. Compound Prescription Drugs.

m. A Disease Specific Drug unless the drug is dispensed by a Network Disease Specific Pharmacy approved by Company. The Network Provider must receive Prior Authorization from the Company. The drug must meet the definition of Disease Specific Drug and must be listed in the Disease Specific Drug Formulary.

n. A Disease Specific Drug if the Member receives financial assistance from a drug manufacturer or if the Member has no obligation to pay for the Disease Specific Drug.

o. Benefits may be reduced if the Member uses a drug manufacturer's coupon which reduces or eliminates the Member's co-pay.

p. Prescription Drugs where Prior Authorization is required in order for Benefits to be provided and Prior Authorization is not obtained.

q. Infant formulas used as a substitute for breastfeeding.

r. Medical Food administered enterally or orally except as covered under Medical Policy.

s. Prescription Drugs for which Benefits are sought by the Member when the Member has failed to comply with the Company's Prescription Drug Care Management requirements with regard to the Prescription Drugs.

6. Outpatient Occupational Therapy, except as provided through Physical Medicine.

7. For treatment related to sex transformations, sexual function, sexual dysfunctions or inadequacies regardless of Medical Necessity, unless required by law.

8. Elective abortions including, however not limited to, the Member's request for payment of prescription abortifacients (Exception: Upon proper documentation from the Member's Provider, Company may determine that the elective abortion procedure was Medically Necessary in order to preserve the life or physical health of the mother).

9. Services and supplies related to infertility, artificial insemination, intrauterine insemination and in-vitro fertilization regardless of any claim of Medical Necessity.

10. Provider services or supplies rendered or furnished prior to the Member's Effective Date or subsequent to Member's termination date.

11. Charges for services paid or payable under Medicare Parts A or B when the Member has Medicare coverage.

12. Provider services, supplies, or charges to the extent payment has been made or is available under any other contract issued by this or any other Blue Cross or Blue Shield Company, or to the extent provided for under any other group Benefit Plan.

13. Acupuncture, anesthesia by hypnosis, or charges for anesthesia for non-covered services.

14. Cosmetic Surgery, Cosmetic Services, and any complications resulting from Cosmetic Surgery or Cosmetic Services. Cosmetic Services include, but are not limited to, dermal fillers, laser vein treatment, laser hair removal, laser tattoo removal, cosmetic removal of moles & skin tags, dermabrasion, chemical peel, and electrolysis.

15. Services or expenses for which the Member has no legal obligation to pay, or for which no charge would be made if the Member had no health coverage.

16. Services or supplies which are not prescribed by or performed by or upon the direction of a Physician or Allied Health Professional.

17. Services or supplies rendered by Providers other than those specifically covered by this Benefit Plan.

18. Any treatment, procedure, facility, equipment, drug, device, or supply not yet recognized as accepted medical practice for the treatment of the condition being treated, and therefore, not considered Medically Necessary.

19. Any injury, illness or condition for which a claim has been or will be pursued under any worker's compensation laws. If no claim has been or will be pursued or where there is ultimately no recovery of any type under the applicable worker's compensation laws, Benefits of this Benefit Plan will be available (see Article XV, Subrogation-Work Related).

20. Any injury growing out of an act or omission of another party for which a claim or recovery is or will be pursued. If no claim or recovery is or will be pursued, Benefits otherwise will be available under the terms of this Benefit Plan (see Article XV, Subrogation-Third Party).

21. By any governmental Hospital such as a charity Hospital, mental institution or sanatorium, except in those cases where enforcement of this exclusion would be prohibited by Federal law or the laws of the State of Mississippi.

22. Diseases contracted or injuries sustained as a result of war, declared or undeclared, or any act of war.

23. Care received from a dental or medical department maintained by or on behalf of an employer, a mutual Benefit association, labor union, trust, or similar person or group.

24. Care rendered by a Provider who is a first degree relative of the Member by blood or marriage or who regularly resides in the Member's household.

25. Personal comfort, personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, shower chairs or personal fitness equipment.

26. Charges for telephone Consultations, failure to keep a scheduled visit, completion of a claim form, or to obtain medical records or information required to adjudicate a claim(s).

27. For palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, care of corns, bunions (except capsular or bone Surgery), calluses, toenails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet, except for preventive or routine foot care rendered to a Member with a diagnosis of Diabetes. Preventive or routine foot care is limited to the Covered Services specified in Article VI.

28. Any surgical procedure that is performed in order to correct a visual acuity defect that can be corrected by contact lens or glasses is not eligible for coverage.

29. Travel, whether or not recommended by a Physician, except as specified under Ambulance Services Benefits and Organ Transplant Benefits.

30. Weight reduction programs or treatment for obesity including any Surgery for morbid obesity or for removal of excess fat or skin following weight loss, regardless of Medical Necessity, or Services at a health spa or similar facility.

31. Treatment of any Member in the custody of any law enforcement entity or confined in a prison, jail, or other penal institution.

32. Dental Care and Treatment, Dental Surgery, and dental appliances except as specified in this Benefit Plan.

33. For persons age of 19 and older, benefits will not be provided for eyeglasses, contact lenses, eye exercises, orthoptic therapy or eye care due to decreased visual acuity or other visual complaints to determine the refractory state of the eye or eyes for the prescribing or fitting of glasses or contact lenses or orthoptic therapy. For individuals under the age of 19, benefits will not be provided for: vision training; special lens designs or coating, other than scratch resistant coating for plastic lens; replacement of lost eyewear; plano lenses; or two pairs of eyeglasses in lieu of bifocals.

34. Home Health services provided by a Home Health Agency except as specified in this Benefit Plan.

35. Nursing home care, custodial home care, skilled nursing, long term acute care, or extended care facility services, regardless of the level of care required or provided.

36. Respite Care.

37. Industrial testing, job screenings or self help programs (including, but not limited to stress management programs).

38. Work hardening programs.

39. Any care or service not specified as a Covered Service.

40. Supplies or equipment used or related to Infusion Therapy except as provided in Article VIII, Infusion Therapy.

41. Care of a newborn not covered at birth as a Dependent except as otherwise required by law with regard to an ill newborn.

42. Provider services or supplies which are not documented to be Medically Necessary as determined by Company.

43. Inpatient Hospital services and supplies for Rehabilitative Care and treatment except as provided in this Benefit Plan (See Hospital Benefits).

44. School, camp, work, and sports physicals and disability examinations including, but not limited to, immunizations required for travel or school.

45. Preventive or wellness care provided at a worksite or school, or by a Certified Nurse Mid-wife, and preventive or wellness services except as provided by this Benefit Plan.

46. For reversal of a voluntary sterilization procedure.

47. Nervous/Mental and Substance Use Disorder Benefits do not include: 1) counseling services such as career counseling, marriage counseling, divorce counseling, parental counseling, and job counseling; 2) services for anger management, hypnotherapy, yoga, equine therapy, acupuncture, harmonic resonance therapy, nutritional counseling, biofeedback, didactic group education, relaxation therapy, individual psychodynamic therapy, unstructured group therapy, or confrontation therapy as a principal treatment approach; 3) custodial care, situation or environmental change; 4) facilities or settings such as therapeutic community, therapeutic group homes, apartment living associated with treatment, sober living houses, day-care, school settings, Oxford House models, half-way houses and home-based; 5) therapeutic camps (e.g., wilderness and Outward Bound, etc); 6) court-ordered treatment determined to not be Medically Necessary; 7) any programs performed and/or offered by public schools, including educational, required by federal or state law to be performed and/or offered by public schools, including, but not limited to, Individualized Education Programs, Special Education Services, and Individuals with Disabilities Education Improvement Act programs, Attention Deficit Disorder Classrooms; Autism Spectrum Disorders Classrooms or Applied Behavioral Analysis (ABA); and 8) treatment for behavioral, learning disabilities or intellectual disabilities.

48. Organ and tissue transplants (autologous and allogeneic) except as provided in Article XII.

49. Services, care, treatment or supplies which are furnished or rendered after the cancellation or termination date of the Member's coverage (whether or not such services, care, treatment or supplies are for or related to a condition, disease, ailment or injury which commenced before or existed on the termination date of the Member's coverage).

50. Speech Therapy for learning disabilities and development problems which do not qualify as Habilitative Care.

51. Pre-Admission Testing.

52. Private Duty Nursing.

53. Drugs that are prescribed by a Provider in order to enhance the Member's performance in certain activities (example: blood enhancing drugs).

54. Dental Implants.

55. Hot tubs, swimming pools, whirlpools, lift chairs, and air purifiers, regardless of the Provider's recommendation.

56. For alterations or structural changes to the Member's home, auto or personal property to accommodate any Durable Medical Equipment. Equipment that does not meet the Company's definition of Durable Medical Equipment will also be excluded for Benefits.

57. Research and testing utilized for determining the cause of a miscarriage or a spontaneous abortion.

58. Charges for all medical complications which arise as the result of the Member receiving non-covered medical, surgical or diagnostic services. Examples of non-covered medical, surgical or diagnostic services include, but are not limited, to gastric bypass surgery, liposuction, cosmetic surgery, and elective abortions.

59. Charges for braces or any surgery used to treat or cure micrognathism and macrognathism when it is for cosmetic purposes as determined by Company.

60. Illness or injury which is caused by the Member's unlawful possession of any item or substance or possession of any item or substance for an unlawful purpose.

61. Any hearing aids (air or bone conduction), speech generating devices, or listening devices, or for examination or fitting regardless of Medical Necessity.

62. Telehealth performed by Providers other than Telemedicine Network Providers in accordance with Medical Policies.

63. In a Specialty Service Area, Specialty Services will only be covered by a Center of Excellence Network Provider or a Specialty Care Designated Provider.

64. Clinical Trials performed by Non-Network Providers or if the Member receives financial assistance from third parties.

65. Services provided pursuant to any direct primary care agreement, fee-for-service agreement, or similar arrangement in which the Member directly pays a health care provider a fee in exchange for the provision of medical services that are not to be billed to any insurance company or other third party.

66. Services provided solely to improve cognition (e.g., memory or perception), concentration and/or attentiveness, organizational or problem-solving skills, academic skills, impulse control or other behaviors for which behavior modification is sought.

67. Member/patient initiated to Provider online medical evaluation and management unless performed by a Blue Primary Care Provider who is also a Telemedicine Network Provider. Online medical evaluation and management, which is an evaluation and management services not performed in-person with the patient by a provider in response to a patient's online inquiry, is a type of low complexity clinician interactive visit which requires an audio visual online communication to address urgent but not emergent clinical conditions.

68. Genetic testing, even if Medically Necessary, performed by a Provider who is not certified by the College of American Pathologists (CAP) and Clinical Laboratory Improvement Amendments (CLIA) Certified.

69. Services provided by Non-Network Independent Laboratories.