

Except as may be specifically provided in the Description of Benefits section, the following are not covered under the Policy:

1. Services which are not Medically Necessary.
2. Any services in connection with or required by a non-covered procedure or benefit, except:
 - a. as necessitated by subsequent complications; and
 - b. any normally covered patient costs, that are directly associated with an approved cancer clinical trial that is offered in this state and in which the insured participates voluntarily
3. Services in excess of any benefit Maximum as stated in the Schedule of Benefits section.
4. Charges for services or supplies incurred prior to the Insured's Effective Date.
5. Except as provided in the General Provisions section, charges for services or supplies incurred after the date of termination of the Insured's coverage.
6. Charges, which exceed the Allowable Charge.
7. Services or supplies, which are not prescribed or performed by or under the direction of a Physician or Professional Provider when pre-approval required.
8. Services which Significa determines are Experimental or Investigative (except for the cancer clinical trials noted); the fact that a treatment, procedure, equipment, drug, device or supply is the only available treatment for a particular condition will not result in coverage if the service is considered to be Experimental or Investigative. Coverage will not be provided for services related to medical research.
9. Loss sustained or expenses incurred while on active duty as a member of the armed forces of any nation; or losses sustained or expenses incurred as a result of act of war whether declared or undeclared.
10. Treatment or services received as a result of an Insured's participation in a riot or insurrection.
11. Services as a result of injuries sustained during an Insured's commission of or attempt to commit an illegal act.
12. Services for which an Insured would have no legal obligation to pay.
13. Services performed when traveling outside the United States, with the exception of Emergency Care.
14. Cosmetic or Reconstructive Procedure/Surgery to improve the appearance or performed for psychological or psychosocial reasons, unless required for correction of a condition directly resulting from accidental injury; for a newborn to correct a congenital birth defect; for breast reconstruction following Mastectomy; or for the treatment of complications resulting from surgery.
15. The following procedures are not covered: removal of skintags; treatment of alopecia; dermabrasion; diastasis recti repair; ear or body piercing; electrolysis for hirsutism; excision or treatment of decorative or self-induced tattoos; salabrasion; chemosurgery and other such skin abrasion procedures associated with the removal of scars; hairplasty; lipectomy and panniculectomy; otoplasty; rhytidectomy; blepharoplasty; actinic changes; chemical peels; surgical treatment of acne; removal of port wine lesions, except when involving the visible portion of the face; augmentation mammoplasty, except to establish symmetry following surgery for breast disease; removal, repair or replacement for a breast implant, except following Mastectomy; reduction mammoplasty, except to establish symmetry following Mastectomy; gynecomastia, except when mandated for breast disease; echosclerotherapy for treatment of varicose veins; non-invasive laser treatment of superficial small veins, and treatment of spider veins, or superficial telangiectasias.
16. All dental services including preventive dental care, regardless where or by whom performed, related to the care, filling, removal or replacement of natural teeth, dentures or bridges and treatment of diseases of the teeth or gums, including, but not limited to: treatment of dental cavities, periodontics, endodontics, orthodontics, and orthognathic surgery, except as required for correction of a condition caused by accidental injury, for hospital and anesthesia charges associated with Medically Necessary dental procedures requiring sedation, which cannot be safely or adequately performed on an Outpatient basis upon authorization of Significa's Medical Director, including those for children under the age of eighteen (18) and for adults with severe mental retardation, and for dental services for baby bottle syndrome prior to age four (4) once per life time. Treatment of temporomandibular joint disorder (TMJ/TMD) or myofascial pain dysfunction (MPD) or craniomandibular (CMD) pain syndrome, including surgical and non surgical exam, invasive and non invasive procedures and tests, and all related medical and surgical services. Examples of non-covered services include, but are not limited to: physiotherapy, therapeutic muscle exercises, occlusal appliances or other oral prosthetic devices and their adjustments, braces, crowns, or bridgework.
17. Services for which benefits are available under Medicare or other governmental programs, due to the Insured's enrollment in such governmental programs, except Medicaid, a state or federal workers' compensation, employer's liability or occupational disease law or services provided by a member of the covered person's immediate family.
18. Treatment of pervasive developmental disorders such as autism or mental retardation, defects, deficiencies and learning disabilities. This exclusion does not apply to medical treatment of such Insured Persons in accordance with the benefits provided in the Description of Benefits section.
19. Biofeedback/neurofeedback.
20. Charges for the procurement of blood or for blood storage or the cost of securing the services of professional blood donors; cord blood collection, preparation or storage.
21. Routine and cosmetic foot care.
22. The repair and replacement of Orthoses.
23. Sports medicine treatment plans, corrective appliances, or artificial aids primarily intended to enhance Athletic functions, or work hardening programs.
24. Custodial Care, domiciliary care, convalescent care, or rest cures, Private Duty Nursing or specialized nursing care.
25. Nutritional therapy, vitamin, mineral and electrolyte supplements, food, special diets, and feedings for adults, children and infants except those providing at least thirty-five percent (35%) of daily caloric requirements given enterally through an in-dwelling gastrointestinal tract tube necessitated by the inability to take nutrition by mouth, or in conditions of gastrointestinal tract impairment, parenterally through an intravenous catheter. Infant formulas including those prescribed for reasons of fat malabsorption, lactose intolerance, milk protein intolerance and/or milk allergies. Metabolic formulas, except those that are mandated to be covered by law for the therapeutic treatment of phenylketonuria (PKU), branched-chain ketonuria, galactosemia and homocystinuria.
26. The purchase of organs which are sold rather than donated to transplant recipients and charges for organ donor searches are also excluded from coverage.
27. Charges incurred as a result of illness or bodily injury covered by any Workmen's Compensation Act or Occupational Disease Law or by United States Longshoreman's Harbor Worker's Compensation Act and first party valid and collectible claims covered by a motor vehicle policy issued or renewed pursuant to this state's Motor Vehicle Insurance Law or any applicable federal or state law. This exclusion applies regardless of whether the Insured claims the benefit compensation.
28. Long-Term Residential Care.
29. Therapy or rehabilitation, except as provided in the Description of Benefits section.
30. Therapy or devices to correct stuttering or pre-speech deficiencies or to improve speech skills that are not fully developed.

31. Reversal of voluntary sterilization.
32. Treatment in connection with transsexual surgery, except for treatment resulting from a complication of such transsexual surgery.
33. Charges in connection with penile implants.
34. Abortions, except however, services which are necessary to avert the death of the woman and services to terminate pregnancies caused by rape or incest will be covered.
35. Charges in connection with surrogate parenting, except that coverage will be provided for Covered Services to the birth mother when she is an Insured under the Policy.
36. Corneal surgery to change the shape of the cornea to correct vision problems, except for accidental injury or Medically Necessary conditions resulting from corneal surgery.
37. Except as provided in the Description of Benefits section, routine eye examinations; refractions for eyeglasses or contact lenses; all services associated with eyeglasses or contact lenses, including related diagnostic tests such as, but not limited to: visual fields testing, orthoptics, syntonics, optometric therapy, vision augmentation devices and vision enhancement systems.
38. Services or supplies for personal hygiene, physical fitness or convenience items, whether or not prescribed by a Physician, such as but not limited to allergen filtration systems, including allergy products.
39. Charges for telephone calls or telephone consultations, for failure to keep a scheduled visit, for completion of forms, transfer or copying of records or generation of correspondence.
40. Charges for services, use of facilities, or supplies that any covered person has no legal obligation to pay.
41. Assisted fertilization techniques such as, but not limited to, artificial insemination, In Vitro Fertilization (IVF) of any kind including the office visits, drugs, diagnostic monitoring (ultrasound) and other services and supplies related to these procedures, including, but not limited to: oral or injectable prescription medication treatment, embryo acquisition, storage and transport, human chorionotropin, urofollitropin, menotropins or derivatives, donor ovum and semen and related costs, including collection, preparation, preservation of storage.
42. Provision or replacement of the following items, including but not limited to: (a) deluxe equipment of any sort, or equipment which has been otherwise determined by Significa to be non-standard; (b) items which are primarily for personal comfort or convenience, including but not limited to: bedboards, air conditioners, and over-bed tables; (c) disposable supplies, such as elastic bandages, support stockings, ostomy supplies, or self-administered catheters or prosthetic socks, except when administered by a home health agency as part of the home health benefit; (d) exercise equipment; (e) self-help devices, including, but not limited to: lift-chairs, saunas, humidifiers, and air purifiers; (f) repair or replacement of any device or piece of equipment; (g) any device or piece of equipment which is no longer Medically Necessary; (h) motor vehicles, or any modification to any vehicle for use of a disabled person; (i) dental services or appliances of any sort, including, but not limited to: dentures, bridges, dental implants, or intra-oral Prostheses; (j) hearing aids, eyeglasses or contact lenses, except as provided in the Description of Benefits section; (k) corsets; (l) supportive back brace without metal stays; (m) knee brace made of elastic fabric support or sports braces; (n) comfort, non-therapeutic cast-brace; (o) pro-glide Orthosis; (p) garter belts, rib belts, or pressure leotards; (q) spinal pelvic stabilizers; (r) nose braces; (s) tongue retainers (equalizer, positioner); (t) slings and other non-sterile or over-the-counter supplies; (u) other special appliances, supplies, or equipment, including bio-mechanical devices; and (v) modification or customization of any Durable Medical Equipment.
43. Examinations for the prescription, fitting or adjustment of hearing aids.
44. Travel or transportation expenses, even though prescribed by a Physician, except ambulance service as outlined in the Description of Benefits section.
45. Services performed by a Provider with the same legal residence as an Insured or who is a family Insured Person, including spouse, brother, sister, parent or child.
46. Alternative and complementary medicine.
47. Adult circumcision in the absence of disease.
48. Charges for a private room when a Semi-Private Room is available.
49. Services, which are not prescribed, performed or directed by a Provider licensed to do so.
50. Educational classes, nutritional counseling programs, support groups and disease management programs unless sponsored or provided by Significa or required for diabetes education services.
51. Separate charges by interns, residents and other health care professionals who do not have a Preferred Provider Agreement with Significa, who are directly, or indirectly, employed by a Hospital or Facility Provider which is a Preferred Provider with Significa and makes their services available.
52. Take-home Drugs, both prescription and non-prescription, dispensed by a Pharmacy, Facility Provider or Professional Provider; fertility Drugs regardless of use; Drugs in certain Drug classes specifically designated by Significa as Specialty Drugs including, but not limited to: self-administrable injectables, such as antihemophilic agents, hematopoietic agents, anticoagulants, growth hormones, enzyme replacement agents, immunomodulators, immunosuppressives unless provided in connection with covered transplants, monoclonal antibodies, and other biotech Drugs; except those Drugs administered by a Preferred Professional Provider that are not self-administrable and/or that are provided incident to a Covered Service; and those Drugs that are mandated to be covered by law.
53. Charges for any Prescription Drug or supply, which is not Medically Necessary and appropriate based on one (1) or more of the following reasons:
 - a. the indication and/or use is of a cosmetic nature or to enhance physical appearance; to enhance athletic performance; or for weight loss.
 - b. based on the Pharmacist's professional judgment, the Prescription should not be dispensed.
 - c. the Prescription Drug or supply is subject to Prior Authorization and has not been authorized as an exception, (based on, and supported by, medical justification from the Prescriber) for the following reason:
 - 1) The use of the Prescription Drug or supply is contraindicated due to: overutilization, Drug-Drug interaction, Drug-disease interaction, therapeutic duplication, adverse reaction, or Drug allergy.
 - 2) The use of the Prescription Drug or supply is subject by Significa to utilization review criteria.
54. Charges for any Prescription Drug or supply, unless authorized in accordance with the General Provisions or Description of Benefits sections of the Policy, which are:
 - a. Experimental or Investigative;
 - b. not approved for use by the Food and Drug Administration;
 - c. not approved for the specific indication by the Food and Drug Administration;
 - d. Drugs which do not require a prescription;
 - e. Drugs which cannot be self-administered;
 - f. medical supplies; devices and equipment,
 - g. test agents and devices, except those used for diabetes;
 - h. smoking-cessation aids, including nicotine patches, gums and nasal sprays, except Prescription Drugs specifically designated by Significa;
 - i. multiple vitamins, except those used for pregnancy and multiple vitamins with fluoride for the prevention of dental caries in children under the age of sixteen (16);
 - j. injectable Drugs used to treat infertility;
 - k. the additional charge for a brand-name Drug for which there is a Generic Equivalent Drug available;
 - l. Drugs for impotence in excess of four (4) doses per month;
 - m. allergy extracts for allergen immunotherapy;
 - n. administration or injection of any Drugs;
 - o. replacement of lost, stolen or damaged Drugs.

Off-label Drug use means the use of a Drug that is approved by the Food and Drug Administration for the treatment of one medical condition, but is used to treat another medical condition.

This is an abridged overview that highlights general benefits and features and is not intended to be a substitute for the terms, provisions, limitations, and conditions imposed by the controlling contract(s) issued by Significa Insurance Group, Inc.