

Exclusions

Unless otherwise set forth in a Rider, the following is a list of services that are not typically covered under UPMC Health Plan commercial employer group benefit plans.

1. **Alternative Medicine:** Acupuncture, except as set forth in this Certificate of Coverage. Acupressure, aromatherapy, ayurvedic medicine, guided imagery, herbal medicine, homeopathy, massage therapy, naturopathy, relaxation therapy, transcendental meditation, or yoga.
2. **Assisted Fertilization:** Assisted fertilization services, unless you have an Infertility Rider, including, but not limited to, GIFT, ZIFT, embryo transplants, in vitro fertilization, reversal of voluntary sterilization procedures, and sex transformation services and procedures.
3. **Behavioral Health Services:**
 - A. Any psychotherapy, psychiatric care, or treatment services for mental health or substance use which are court-ordered, unless such services meet medical necessity criteria.
 - B. Inpatient or outpatient treatment related to mental retardation, pervasive developmental disorder, or autism, which extends beyond traditional medical management, unless covered by an Autism Spectrum Disorders Coverage Rider attached to this Certificate of Coverage.
 - C. Treatment for personality disorders where that is the primary diagnosis.
 - D. Eligibility for and maintenance of Social Security disability benefits does not determine whether UPMC Health Plan will cover specific behavioral health or substance abuse treatment services. Medical necessity criteria will be used to determine whether specific treatment services are covered.
 - E. Any treatment/services related to personal or professional growth/development, educational or professional training or certification, or treatment services required for investigative purposes related to employment.
 - F. Any services necessary to obtain or maintain employment or insurance or for judicial or administrative proceedings, including, but not limited to, adjudication of material, child support, or custody cases.
 - G. Methadone maintenance for the treatment of chemical dependency.
 - H. Treatment for chronic behavioral conditions, once you have been restored to the pre-crisis level of function.
 - I. Marriage or family counseling, except when rendered in connection with services provided for a treatable mental disorder.
 - J. Chronic maintenance therapy, except in the case of serious mental illness.
 - K. Aversion therapy, bioenergetic therapy, carbon dioxide therapy, confrontation therapy, crystal healing therapy, cult deprogramming, electrical aversion therapy for alcoholism, narcotherapy, orthomolecular therapy, primal therapy, expressive therapies, such as art or psychodrama, and hyperbaric or other therapy.
 - L. Sex therapy without a diagnosis as defined by the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM).
 - M. Sedative action electrostimulation therapy.
 - N. Sensitivity training.
 - O. Twelve step model programs as sole therapy for conditions, including, but not limited to, eating disorders or addictive gambling.
 - P. Treatment or consultation provided by the members' parents, siblings, children, current or former spouse or domiciliary partner.
 - Q. Truancy or disciplinary problems not associated with a treatable mental disorder.
 - R. Psychoanalysis or other therapies that are not short-term or crisis-oriented.
 - S. Psychological and neuropsychological testing for learning disabilities or problems, other school-related issues, to obtain or maintain employment, to submit a disability application for a mental or emotional

condition, and any other testing that does not require administration by a licensed behavioral health professional, including self-test reports.

- T. Long-term residential treatment services for behavioral health disorders, including, but not limited to, substance use and eating disorders.
 - U. Intensive health coaching services, resource coordination activity, behavioral health rehabilitation services for children and adolescents, and summer camp programs are not covered services, unless covered by an by an Autism Spectrum Disorder Coverage Rider attached to this Certificate of Coverage.
 - V. Skilled nursing facility care provided for treatment of a mental illness or treatment of substance abuse or dependency.
 - W. Respite services.
4. **Blood:** Non-purchased blood or blood products, including autologous donations.
 5. **Corrective Appliances:** Corrective appliances primarily intended for athletic purposes or related to a sports medicine treatment plan and other appliances or devices, or any related services, including, but not limited to, children's corrective shoes, arch supports, special clothing or bandages of any type, back braces, lumbar corsets, hand splints, shoe inserts, or orthopedic shoes, unless otherwise set forth herein.
 6. **Cosmetic Surgery:** Surgical or other services for cosmetic purposes performed to repair or reshape a body structure for the improvement of the person's appearance or for psychological or emotional reasons and from which no improvement in physiological function can be expected, except as such surgery or services are required to be covered by law. Excluded services include, but are not limited to, port wine stains, augmentation procedures, reduction procedures, and scar revisions.
 7. **Court Ordered:** Court-ordered services when your physician or other professional provider determines that those services are not medically appropriate.
 8. **Custodial Care:** Custodial care, domiciliary care, residential care, or protective and supportive care, including, but not limited to, respite care, rest cures, educational services, convalescent care, dietary services, homemaker services, maintenance therapy, and food or home-delivered meals.
 9. **Dental Care:** Except as otherwise set forth herein, services directly related to care, treatment, removal, or replacement of teeth, the treatment of injuries to or diseases of the teeth, gums, or structures directly supporting or attached to the teeth, including, but not limited to, treatment of dental abscesses or granuloma, treatment of gingival tissues (other than for tumors), and dental examinations, unless you have a Dental Rider.
 10. **Employment Related or Employer Sponsored Services:**
 - A. For any illness or bodily injury that occurs in the course of employment, if benefits or compensation is available in whole or in part, pursuant to any federal, state, or local government's workers' compensation, or occupational disease, or similar type of legislation. This exclusion applies whether or not you claim those benefits or compensation.
 - B. Services that you receive from a dental or medical department, operated in whole or in part by, or on behalf of, an employer, mutual benefit association, labor union, trust, or similar entity.
 11. **Experimental/Investigational:** Services that are Experimental/Investigational in nature as determined by UPMC Health Plan.
 12. **Food Supplements/Vitamins:** Food, food supplements, vitamins, and other nutritional and over-the-counter electrolyte supplements, except otherwise set forth herein.

13. **Genetic Counseling Studies:** Genetic counseling and studies not Medically Necessary for treatment of a defined medical condition.
14. **Growth Hormones:** Growth hormone therapy unless prescribed for Classic Growth Hormone Deficiency, Turner's Syndrome, or certain other diagnoses as determined by UPMC Health Plan and authorized in accordance with applicable policy and procedure.
15. **Hearing Aids:** Hearing aids, examinations for the prescription or fitting of hearing aids, and batteries for hearing aids.
16. **Hearing Examinations:** Routine hearing examinations and related services.
17. **Home Care:** Home care for chronic conditions such as permanent, irreversible disease, injuries, or congenital conditions requiring long periods of care or observation.
18. **Home Medical Equipment:** Comfort or convenience items, for your comfort or convenience or the comfort or convenience of your caretaker, including, but not limited to, fitness club memberships, air conditioners, televisions, telephones, dehumidifiers, air purifiers, food blenders, exercise equipment, orthopedic mattresses, home or automobile modifications, whirlpools, barber or beauty service, guest service or similar items, even if recommended by a professional provider. Medical equipment and supplies that are (a) expendable in nature (i.e., disposable items such as incontinent pads, catheters, irrigation kits, disposable electrodes, ace bandages, elastic stockings, and dressings) and (b) primarily used for non-medical purposes, regardless of whether recommended by a professional provider.
19. **Immunizations and Drugs:** Physical examinations and immunizations required by foreign travel, school, or employment.
20. **Medical/Dental Services Not Provided in this Certificate of Coverage:** Any other medical or dental service or treatment, except as provided in this Certificate of Coverage or as mandated by law.
21. **Medically Unnecessary Services:** Services that are not Medically Necessary as determined by UPMC Health Plan.
22. **Medicare:** Services for which or to the extent that payment has been made pursuant to Medicare coverage, when Medicare coverage is primary; however, this exclusion does not apply when your employer or group plan sponsor is required to offer you all of the benefits set forth in this Certificate of Coverage by law and you elect this coverage as your primary coverage.
23. **Medicare Eligibility:** Any amounts that you are required to pay under the Deductible and/or Coinsurance provisions of Medicare or Medicare supplement coverage.
24. **Mental Retardation:** Any amounts that you are required to pay under the Deductible and/or Coinsurance provisions of Medicare or Medicare supplement coverage. Inpatient or outpatient treatment related to mental retardation, pervasive developmental disorder, or autism, which extends beyond traditional medical management.
25. **Military Service:**
 - A. Care for military service-connected disabilities and conditions for which you are legally entitled to services and for which facilities are reasonably accessible to you.
 - B. Services that are provided to members of the armed forces and the National Health Service or to individuals in Veterans Administration facilities for military service-related illness or injury, unless you have a legal obligation to pay.

26. **Miscellaneous:** Any services, supplies, or treatments not specifically listed in the Certificate of Coverage as Covered Benefits, services, supplies, or treatments, unless they are a basic health service.
- A. Services and supplies which are not provided or arranged by a UPMC Health Plan physician and authorized for payment in accordance with UPMC Health Plan's medical management policies and process.
 - B. Any services related to or necessitated by an excluded item or non-Covered Service.
 - C. Services provided by a non-licensed practitioner or practitioner not recognized by UPMC Health Plan.
 - D. Services that are primarily educational in nature, including, but not limited to, vocational rehabilitation or recreational or educational therapy.
 - E. Services incurred after the date of termination of your coverage, except as provided elsewhere in this Agreement. Services rendered prior to the effective date of your coverage.
 - F. Services for which you otherwise would have no legal obligation to pay.
 - G. Charges for telephone consultations.
 - H. Charges for failure to keep a scheduled appointment.
 - I. Services performed by a professional provider enrolled in an education or training program when such services are related to the education or training program.
 - J. Charges for completion of any insurance form or copying of medical records.
 - K. Services rendered by a professional provider who is a member of your immediate family. Immediate family is defined as the member's spouse, child, stepchild, parent, sibling, son-in-law, daughter-in-law, mother-in-law, father-in-law, sister-in-law, brother-in-law, or grandparent.
 - L. Services that are submitted by two different professional providers for the same services performed on the same date for the same individual.
 - M. Services for, or related to, any illness or injury suffered after the effective date of your coverage that is the result of any act of war.
27. **Motor Vehicle Accident/Workers' Compensation:** Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a motor vehicle insurance policy, including, but not limited to, a qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law, including medical benefits payment in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Act or equivalent law of another state.
28. **Non-Medical Items:** Health club memberships, air conditioners, televisions, telephones, dehumidifiers, air purifiers, food blenders, exercise equipment, orthopedic mattresses, home or automobile modifications, whirlpools, barber or beauty service, guest service or similar items, even if recommended by a physician.
29. **Nutritional Supplements:** Blenderized food, baby food, or regular shelf food when used with an enteral system; milk- or soy-based infant formula with intact proteins; any formula, when used for the convenience of you or your family members; nutritional supplements or any other substance utilized for the sole purpose of weight loss or gain, or for caloric supplementation, limitation, or maintenance; oral semisynthetic intact protein/protein isolates, natural intact protein/protein isolates, and intact protein/protein isolates; food additives, including, but not limited to, thickeners, vitamins, fiber supplements, calorie or protein supplements and lactose digestion products, and normal food products used in the dietary management of rare hereditary genetic metabolic disorders.
30. **Oral Surgery:** Services, including or related to oral surgery, except as otherwise set forth herein. Exclusions include, but are not limited to: (a) services that are part of an orthodontic treatment program; (b) services required for correction of an occlusal defect; (c) services encompassing orthognathic or prognathic surgical procedures; (d) treatment of temporomandibular joint syndrome or temporomandibular joint disorders, except as set forth in this Certificate of Coverage under the Covered Benefits section the

Medical/Surgical Services subsection; (e) removal of asymptomatic, non-impacted third molars; and (f) orthodontia and related services.

31. **Over-the-Counter Drugs:** Food, food supplements, vitamins, and other nutritional and over-the-counter electrolyte supplements, except otherwise set forth herein.
32. **Physical Examinations:** Routine or periodic physical examinations or behavioral health services, the completion of forms, and preparation of specialized reports solely for insurance, licensing, employment, or other non-preventive purposes, including, but not limited to, premarital examinations, physicals for employment, school, camp, and participation in sports or travel, which are not Medically Necessary, except as otherwise set forth herein or as required by law. Physical examinations and immunizations required by foreign travel or employment.
33. **Podiatry Services:** Palliative or cosmetic foot care, including, but not limited to: (1) treatment of weak, strained, flat, unstable, or unbalanced feet; (2) metatarsalgia or bunions (except open cutting procedures); and (3) treatment of corns, calluses, or toenails (except removal of nail roots) if determined to be Medically Necessary by UPMC Health Plan. Supportive orthotic devices for the foot are excluded unless you have diabetes or peripheral vascular disease.
34. **Prescription Drugs:** Prescription drugs unless you have a Prescription Drug Rider.
35. **Rehabilitative Therapy:** Rehabilitative therapy services, including, but not limited to, physical therapy, occupational therapy, and speech therapy provided to correct or alleviate developmental delay, school-related problems, apraxic disorders (not caused by accident or episodic illness), stuttering, speech delay, articulation disorder, functional dysphonia, or speech problems resulting from psychoneurotic or personality disorders. Physical, occupational, and speech rehabilitation therapy services provided in excess of the maximum number of visits per Benefit Period, as indicated in the schedule of benefits; cardiac rehabilitation services provided in excess of twelve (12) weeks; pulmonary rehabilitation services provided in excess of twenty-four (24) visits per Benefit Period; rehabilitation therapy services not expected to result in ongoing substantial improvement in your medical condition; and services provided after a maintenance level has been established.
36. **Reversal of Voluntary Sterilization Procedures:** Services to reverse sterilization.
37. **Sex Transformation Services and Procedures:** Treatment leading or related to transsexual surgery, except for sickness or injury resulting from such treatment or surgery.
38. **Smoking Programs:** Nicotine cessation programs and/or classes and prescription and non-prescription medication prescribed for cessation of smoking unless you have a smoking cessation benefit rider that provides such benefits.
39. **Surrogate Motherhood:** Services and supplies associated with surrogate motherhood, including, but not limited to, all services and supplies relating to conception, prenatal care, delivery, and postnatal care of a member acting as a surrogate mother.
40. **Temporomandibular Joint Syndrome:** Treatment of temporomandibular joint syndrome or temporomandibular joint disorders, regardless of the nature of the problem, except as set forth in this Certificate of Coverage.
41. **Transportation:** Routine or non-emergent transportation, by any means, including via ambulance provider, unless such transportation is prior authorized by UPMC Health Plan.

42. **Treatment Outside the United States:** Treatment for non-emergent or non-urgent services received outside the United States.
43. **Vision:**
- A. Eyeglasses and contact lenses and vision examinations, including those for prescribing or fitting eyeglasses or contact lenses, unless you have a Vision Rider (except where you have cataracts, keratoconus, or aphakic).
 - B. Services for the correction of myopia, hyperopia, or astigmatism, including, but not limited to, radial keratotomy.
 - C. Vision training for certain diagnoses.
 - D. Orthoptics.
44. **Weight Reduction:** Weight reduction programs, including all related diagnostic testing and other services. Antiobesity medication, including, but not limited to, appetite suppressants and lipase inhibitors.