Exclusions and Limitations

There are no benefits for services, supplies, drugs or other charges that are:

- Not Medically Necessary. If services requiring Prior Authorization by Blue Cross of Rhode Island are performed by a Contracting Provider and benefits are denied as not Medically Necessary, the cost of said services are not the financial responsibility of the Insured. However, the Insured could be financially responsible to the Contracting Provider.
- In excess of the Maximum Allowance.
- For hospital Inpatient or Outpatient care for extraction of teeth or other dental procedures, unless an attending Physician certifies in writing that the Insured has not a dental, life endangering condition which makes hospitalization necessary to safeguard the Insured’s health and life, except as specified as a Covered Service in this Policy.
- Not prescribed by or upon the direction of a Physician or other Professional Provider, or which are furnished by any individuals or facilities other than Generalized Licensed Physicians, Physicians or other Providers.
- Investigational in nature.
- Provided for any condition, Disease, Illness or Accidental Injury in the extent that the Insured is otherwise eligible for benefits under any state or local governmental entity through which his or her claims would otherwise be paid, or would be affected by this exclusion of coverage under the Policy, or for any treatment that has been paid under Medicare Part A and Medicare Part B.
- For any treatment or procedure that is experimental or investigational, except as specified as a Covered Service in this Policy.
- Not directly related to the care and treatment of an actual condition, Illness, Disease or Accidental Injury.
- For any treatment of either gender leading to or in connection with transsexual Surgery, gender reassignment, sex change, sex modification, self-care or self-help training, except as specified as a Covered Service in this Policy.
- For the purchase or treatment of Inpatient or Outpatient Medical Services for the purpose of adjusting an abnormality or malformation of the eyes, even if related to a medical condition.
- For Hearing Aids or examinations for the prescription or fitting of hearing aids.
- For treatment of impotence, even if related to a medical condition.
- For treatment of obesity, except when Surgery for obesity is Medically Necessary to control other medical conditions.
- For any treatment of an actual condition, Illness, Disease or Accidental Injury, except when Surgery for obesity is Medically Necessary to control other medical conditions.
- For pastoral, spiritual, and bereavement counseling.
- For any service or supplies for which an Insured would have no legal obligation to pay in the absence of coverage under the Policy, or for which no charge or a different charge is usually made in the absence of insurance coverage.
- For a routine or periodic physical or mental examination that is not connected with the care and treatment of an actual Illness, Disease, or Accidental Injury or for an examination required in connection with employment, or is not related to a second opinion for a medical condition, or is not related to the care and treatment of a condition.
- For surgery intended mainly to improve appearance, except for:
  - Reconstructive Surgery necessary to treat an actual Illness, injury, defect or Disease of the Insured or parts thereof; or
  - Reconstructive Surgery to correct Congenital Anomalies in an Insured who is a dependent child.
- For Impediment admissions that are primarily for Diagnostic Services, Therapeutic Services, or Physical Rehabilitation, except as specifically provided in the Policy, or for impatient admissions where the Insured is an inpatient and/or outpatient primarily for that care, a special diet, physical, behavioral problems, environmental change or for treatment not requiring continued care.
- For Dependent Occupational Therapy, Dependent Occupational Care, or for Dependent Services consisting mainly of educational therapy, including diabetes education, behavior modifications, self-care or self-help training, except as specified as a Covered Service in the Policy.
- For any cosmetic Inpatient, including but not limited to, treatment of corns, calluses and blemishes (except for surgical care of ingrown or Diseased toenails), or treatments for misalignment or discomfort of the temporomandibular joint (jaw hinge), including splinting jaw; or for orthodontia or occlusion, except as specified as a Covered Service in the Policy.
- For any treatment or service which is intended mainly to improve appearance or for any surgery, surgical procedures or replacement which are excluded, except when required to correct an immediately life-endangering condition.
- For any elective abortion, unless to preserve the life of the female when the abortion is performed.
- For any service, supply, examination, or treatment or equipment furnished by any individual or facility not listed as a Covered Service under the Policy.
- For treatment of injuries sustained while committing a felony, voluntarily taking part in a riot, or while engaging in an illegal act or occupation, except as specified as a Covered Service in the Policy.
- For the treatment of mental or Nervous Conditions, Alcoholism, Substance Abuse or Addictions, or for Pain Management.
- For any service or supply furnished by a facility that is primarily a health resort, sanctuary, residential treatment facility, transitional living center, or primarily a place for treatment or care of Mental or Nervous Conditions except as specified as a Covered Service under the Policy.
- For Any services furnished by any facility of a type that is primarily a health resort, sanctuary, residential treatment facility, transitional living center, or primarily a place for treatment or care of Mental or Nervous Conditions.
- For the treatment of impotence, even if related to a medical condition.
- For treatment or care of mental or Nervous Conditions, Alcoholism, Substance Abuse or Addictions, or for Pain Management.
- For the purchase of Therapies or Services for the purpose of adjusting an abnormality or malformation of the eyes, even if related to a medical condition.
- For services furnished by an individual or facility that is primarily a place for treatment of the aged or that primarily serves a convenience home, or a group home.
- For Acute Care, rehabilitative care, diagnostic testing, evaluation or treatment of Impediment or Dependent Mental or Nervous Conditions, Alcoholism, Substance Abuse or Addictions, or for Pain Management, except as specifically provided as a Covered Service in the Policy.
- For the treatment of injuries sustained while committing a felony, voluntarily taking part in a riot, or while engaging in an illegal act or occupation, except as specified as a Covered Service in the Policy.
- For any service, supply, examination, or treatment furnished by any individual or facility not listed as a Covered Service under the Policy.
- For any service, supply, examination, or treatment furnished by any individual or facility not listed as a Covered Service under the Policy.
- For treatment of injuries sustained while committing a felony, voluntarily taking part in a riot, or while engaging in an illegal act or occupation, except as specified as a Covered Service in the Policy.
- For any treatment or service which is intended mainly to improve appearance, except for:
  - Any services or supplies for which an Insured would have no legal obligation to pay in the absence of coverage under the Policy, or for which no charge or a different charge is usually made in the absence of insurance coverage.
- For any service, supply, examination, or treatment furnished by any individual or facility not listed as a Covered Service under the Policy.
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A LIMITED BENEFIT PLAN

One plan. One price. One number to call. It’s a ratio that most accurately represents our dedication to unparalleled customer service and to you, our number-one priority.

For policies effective on or after October 1, 2010.
**OPTIONS AND BENEFITS**

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<th>ESSENTIAL BLUE PPO 1000</th>
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<tbody>
<tr>
<td><strong>Deductible Choices</strong> (includes in-network and out-of-network covered services)</td>
<td>$1,000 per person – $2,000 per family aggregate*</td>
<td>$2,000 per person – $4,000 per family aggregate*</td>
<td>$3,000 per person – $6,000 per family aggregate*</td>
<td>$5,000 per person – $10,000 per family aggregate*</td>
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<tr>
<td><strong>Coinsurance</strong> (the amount you pay after meeting your deductible, unless otherwise indicated)</td>
<td>You pay 20% of the allowed amount for covered services from in-network providers</td>
<td>You pay 50% of the allowed amount for covered services from out-of-network providers</td>
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<tr>
<td><strong>Out-of-Pocket Maximum</strong> (includes your deductible but does not include $5,000 pregnancy deductible)</td>
<td>$3,000 per person for in-network services</td>
<td>$4,000 per person for in-network services</td>
<td>$5,000 per person for in-network services</td>
<td>$7,000 per person for in-network services</td>
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**Preventive Care Benefits** (including but not limited to: annual physical exams, screening mammograms, pap and PSA tests, cholesterol and diabetes screening, and screening colonoscopies) (see policy for specific list of covered services)

You pay nothing for specifically listed services, not subject to deductible or coinsurance

**Immunizations** (including but not limited to: measles, mumps, tetanus and varicella (chicken pox). (See policy for specifically listed immunizations.)

You pay nothing for specifically listed immunizations, not subject to deductible and coinsurance

**Pregnancy Services** (a separate $5,000 deductible applies, except in cases of involuntary complications)

You pay 20% of the allowed amount for covered services after meeting your deductible

**Emergency Room Facility Services**

You pay a $100 copayment, after which you pay 20% of the allowed amount for covered services after meeting your deductible

**Emergency Room Professional Services**

You pay 20% of the allowed amount for covered services after meeting your deductible

**Hospital Services** (limited to inpatient care, outpatient surgery and preadmission testing)

You pay 50% of the allowed amount for covered services after meeting your deductible

**Inpatient Physical Rehabilitation**

You pay 20% of the allowed amount for covered services after meeting your deductible

**Diagnostic Laboratory and X-ray Services** (inpatient and diagnostic mammograms only)

You pay 20% of the allowed amount for covered services after meeting your deductible

**Hospice Services** (lifetime benefit limit of $10,000 per person)

You pay 50% of the allowed amount for covered services after meeting your deductible

**Selected Therapy Services** (radiation, chemotherapy and renal dialysis)

You pay 20% of the allowed amount for covered services after meeting your deductible

**Inpatient Dental Services Related to Accidental Injury** (covered only for the 12-month period immediately following the date of injury, no coverage for outpatient services)

You pay 50% of the allowed amount for covered services after meeting your deductible

**Skilled Nursing Facility** (limited to 30 days per person, per benefit period)

You pay 50% of the allowed amount for covered services after meeting your deductible

**Transplant Services** ($5,000 travel benefit per benefit period for designated transplants when traveling to and from a Blue Distinction Center for Transplants (BDCT)*)**

You pay 50% of the allowed amount for covered services after meeting your deductible

**Annual Maximum Benefit Limit** (per person, per benefit period; all covered services apply, except for hospice services and Blue Distinction Center for Transplant (BDCT) travel benefits)

You pay 20% of the allowed amount for covered services after meeting your deductible

**$1,250,000**

**SERVICES NOT COVERED UNDER ESSENTIAL BLUE** (See Exclusions and Limitations for complete list of services not covered)

Prescribing Condition

- A condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment during the six months immediately preceding the effective date of coverage;
- A condition for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the effective date of coverage;
- A pregnancy existing on the effective date of coverage under the policy.

Prescribing Condition Waiting Period

- Blue Cross of Idaho shall credit any qualifying previous coverage, as defined by the Individual Health Insurance Availability Act, to the prescribing condition waiting period for new enrollees and dependents. This only applies if there was not more than a 63 day lapse in health coverage prior to the effective date of the new coverage.

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