

Exclusion:

Expenses for the following Hospital Services are excluded when such Services **could have been provided without admitting you** to the Hospital:

1. room and board provided during the admission;
2. Physician visits provided while you were an inpatient;
3. Inpatient Occupational Therapy, inpatient Speech Therapy, inpatient Physical Therapy, and inpatient Cardiac Therapy; and
4. other Services provided while you were an inpatient.

In addition, expenses for the following and similar items are also excluded:

1. gowns and slippers;
2. shampoo, toothpaste, body lotions and hygiene packets;
3. take-home drugs;
4. telephone and television;
5. guest meals or gourmet menus; and
6. admission kits.

Infertility Services

Infertility Services may be covered for a Member who meets the criteria established by HOI, including office visits, diagnosis, and diagnostic procedures to determine the cause of infertility.

Exclusion:

Infertility treatment Services and associated expenses and any outpatient prescription medications for In Vitro Fertilization (IVF); Gamete Intrafallopian Transfer (GIFT) procedures; Zygote Intrafallopian Transfer (ZIFT) procedures; embryo transport; surrogate parenting; donor semen and related costs including collection and preparation; infertility

treatment medications except when used for diagnostic purposes only, are excluded. Laboratory work and treatment of infertility limited to testing, Artificial Insemination, and surgical procedures to correct Conditions causing infertility are also excluded.

Mammograms

Mammograms obtained in a medical office, medical treatment facility or through a health testing service that uses radiological equipment registered with the appropriate Florida regulatory agencies (or those of another state) for diagnostic purposes or breast cancer screening are Covered Services.

Mastectomy Services

Breast cancer treatment including treatment for physical complications for all stages of a Mastectomy (including lymphedemas), and outpatient post-surgical follow-up care in accordance with prevailing medical standards in a manner determined in consultation with you and the attending Physician are Covered Services. Outpatient post-surgical follow-up care for Mastectomy Services shall be covered when provided by a Contracting Provider in accordance with the prevailing medical standards and at the most medically appropriate setting. The setting may be the Hospital, Physician's office, outpatient center, or your home. The treating Physician, after consultation with you, may choose the appropriate setting.

Maternity Care

Health Care Services provided to a Member for pregnancy, delivery, miscarriage, and pregnancy complications, are covered, including the following:

1. routine office visits for prenatal and postnatal care;
2. delivery Services; and

3. postpartum care for the mother including the following: a postpartum assessment provided at the Hospital, the attending Physician's office, at a Birth Center, or in the home by a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Midwife or Certified Nurse Midwife. The postpartum assessment Services include:
 - a) the physical assessment of the mother; and
 - b) performance of clinical tests in keeping with prevailing medical standards.

Under Federal law, a Group Plan generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery; or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 as applicable). In any case, under Federal law, a Group Plan can only require that a provider obtain authorization for prescribing an inpatient Hospital stay that exceeds 48 hours (or 96 hours).

Exclusion:

Prenatal care and delivery outside the Service Area, unless the need for such Services was not, and reasonably could not have been, anticipated before leaving the Service Area.

Note: For newborn child Health Care Services, please refer to the Newborn Child Care category in this section.

Mental Health Services

1. Inpatient:

Inpatient Services for short-term evaluation, diagnosis or Crisis Intervention of a Mental and Nervous Disorder may be covered if authorized in accordance with criteria established by HOI. Coverage is included

for services for the medical and psychological testing associated with the evaluation and diagnosis of mental retardation. These Services must be provided by a licensed Physician, Psychologist, or Mental Health Professional while confined in a Hospital or a Psychiatric Facility for treatment.

Partial Hospitalization for mental health Services may be covered when provided in lieu of inpatient hospitalization.

Note: To be covered, Partial Hospitalization Services must be provided under the direction of a Physician who is a Contracting Provider.

2. Outpatient:

Outpatient treatment of a Mental and Nervous Disorder, including diagnostic evaluation and psychiatric treatment, individual therapy, and group therapy may be covered if authorized in accordance with criteria established by HOI. Treatment must be provided by a licensed Physician, psychiatrist, Psychologist, or Mental Health Professional.

Exclusion:

Mental health Services which are:

1. rendered in connection with a Condition not classified in the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9-CM) or their equivalents in the most recently published version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders;
2. for psychological testing associated with the evaluation and diagnosis of learning disabilities;
3. extended beyond the period necessary for evaluation and diagnosis of learning disabilities or for mental retardation;
4. for marriage counseling when not rendered in connection with a Condition classified in