

# Services/Complications Related to Non-Covered Services

**Policy Number:** BIP107.L  
**Effective Date:** April 1, 2024

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Related Benefit Interpretation Policy
<ul style="list-style-type: none"> <li><a href="#">Services While Confined/Incarcerated</a></li> </ul>

## Federal/State Mandated Regulations

None

## State Market Plan Enhancements

None

## Covered Benefits

**Important Note:** Covered benefits are listed in *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits* sections. Always refer to the *Federal/State Mandated Regulations* and *State Market Plan Enhancements* sections for additional covered services/benefits not listed in this section.

Refer to the member’s Evidence of Coverage (EOC)/ Schedule of Benefits (SOB) to determine coverage eligibility.

UnitedHealthcare will only cover medically necessary emergency health care services needed to stabilize an emergency medical condition associated with complications related to non-covered health care services.

## Not Covered

- UnitedHealthcare does not cover the services or costs related with a service that is not a covered health care service under the member’s UnitedHealthcare Health Plan, including but not limited to cosmetic surgery, bariatric surgery, infertility, and experimental and investigational procedures. This means that UnitedHealthcare will not cover follow-up care or complications related to or arising from a non-covered health care service when:
  - The services or expenses are incurred in preparation for a non-covered health care service;
  - The complications or services are related to a non-covered health care services provided by another health plan or insurance company even if the service was covered under the prior plan;
  - The complications or services are related to a non-covered health care services the member paid for out of-pocket (e.g., cosmetic surgery, bariatric surgery, infertility, experimental and investigational procedures).
  - The non-covered health care services following the stabilization of an emergency medical condition.
- Treatment for an injury or condition due to the member’s commission of a felony or attempt to commit a felony is not covered. This exclusion does not apply to injuries or conditions resulting from an act of domestic violence, or a physical or mental medical condition.
- Services performed by immediate relatives or members of member’s household.

## Policy History/Revision Information

Date	State(s) Affected	Summary of Changes
01/01/2025	All	<b>Template Update</b> <ul style="list-style-type: none"><li>Modified font style; no change to policy content</li></ul>
04/01/2024	All	<ul style="list-style-type: none"><li>Routine review; no change to coverage guidelines</li><li>Archived previous policy version BIP107.K</li></ul>

## Instructions for Use

Covered benefits are listed in three (3) sections: *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits*. All services must be medically necessary. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the member's Evidence of Coverage (EOC)/Schedule of Benefits (SOB). If there is a discrepancy between this policy and the member's EOC/SOB, the member's EOC/SOB provision will govern.