

MEDICAL EXCLUSIONS

Some health care services are not covered by the Plan. In addition to the General Exclusions set forth in the General Limitations and Exclusions section above, these include, but are not limited to, any charge for care, supplies, or services, which are:

Alternative Medicine. For holistic or homeopathic treatment, naturopathic services, and thermography, including drugs, unless the TPA grants an exception.

Biofeedback. For biofeedback, which is considered by the plan to be Investigational.

Education or Training Program. Performed by a Physician or other Provider enrolled in an education or training program when such services are related to the education or training program, except as specifically provided herein.

Gender-Affirming Operation. Related to a gender-affirming operation.

Hair Pieces. For wigs, artificial hair pieces, human or artificial hair transplants, or any Drug, prescription or otherwise, used to eliminate baldness except for hair loss resulting from chemotherapy.

Impregnation and Infertility Treatment. Following charges related to impregnation and infertility Treatment: artificial insemination, fertility Drugs, G.I.F.T. (Gamete Intrafallopian Transfer), impotency Drugs such as Viagra, surrogate mother (unless the surrogate is a Participant, in which case the Preventive Care and/or Pregnancy expenses will be covered in accordance with the Plan provisions), donor eggs, collection or purchase of donor semen (sperm) or oocytes (eggs), and freezing of sperm, oocytes, or embryos, or any type of artificial impregnation procedure, whether or not such procedure is successful.

Obesity. Charges for bariatric surgery, including but not limited to, gastric bypass, gastric sleeves, stapling and intestinal bypass, and lap band surgery, including reversals, related to both obesity and Class III obesity (if BMI is equal to or greater than 40.0 kg/m²). For non-Class III obesity, related to care and treatment of obesity, weight loss or dietary control. This Exclusion does not apply to obesity screening and counseling that are covered under the Preventive Care benefit.

Oral Surgery. For oral surgery or dental treatment, except as specifically provided in the Plan.

Routine Patient Costs for Participation in an Approved Clinical Trial. For costs for participation in an Approved Clinical Trial. The following items are excluded from approved clinical trial coverage under this Plan:

1. The cost of an Investigational new drug or device that is not approved for any indication by the U.S. Food and Drug Administration, including a drug or device that is the subject of the Approved Clinical Trial.
2. The cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in an Approved Clinical Trial.
3. The cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular Diagnosis.
4. A cost associated with managing an Approved Clinical Trial.
5. The cost of a health care service that is specifically excluded by the Plan.

6. Services that are part of the subject matter of the Approved Clinical Trial and that are customarily paid for by the research institution conducting the Approved Clinical Trial.

If one or more participating Providers do participate in the Approved Clinical Trial, the qualified plan Participant must participate in the Approved Clinical Trial through a participating, Network Provider, if the Provider will accept the Participant into the trial.

The Plan does not cover routine patient care services that are provided outside of this Plan's health care Provider Network unless Non-Network benefits are otherwise provided under this Plan.

Sexual Dysfunction. For any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.

Sterilization Reversal. For sterilization procedure reversal.

Tobacco Smoking Cessation. For nicotine withdrawal programs, facilities, Drugs or supplies, except as specified under Preventive Care.

Vision Care. Expenses for the following:

1. For eye refractions, eyeglasses, contact lenses, or the vision examination for prescribing or fitting eyeglasses or contact lenses (except for aphakic patients, and soft lenses or sclera shells intended for use in the treatment of Illness or Injury).
2. For radial keratotomy or other plastic surgeries on the cornea in lieu of eyeglasses.
3. Vision therapy (orthoptics) and supplies.
4. Orthokeratology lenses for reshaping the cornea of the eye to improve vision.