Limitations & Exclusions
This plan does not cover the following services. Please see your policy for more specific information.

General Exclusions
Health care services that we determine are not medically necessary.

Health care services that we determine are experimental/investigational/unproven, except for investigational drugs used for the treatment of HIV infection, as described in Wis. Stat. §632.895 (9).

Health care services provided in connection with any injury or illness arising out of, or sustained in the course of, any occupation, employment, or activity of compensation, profit or gain, for which an employer is required to carry workers' compensation insurance. If you are covered by workers' compensation insurance, this exclusion applies regardless of whether benefits under worker's compensation laws or any similar laws have been claimed, paid, waived, or compromised.

Health care services furnished by the U.S. Veterans Administration, unless federal law designates this policy as the primary payer and the U.S. Veterans Administration as the secondary payer.

Health care services furnished by any federal or state agency or a local political subdivision when you are not liable for the costs in the absence of insurance, unless such coverage under this policy is required by law.

Health care services covered by Medicare, if you have or are eligible for Medicare, to the extent benefits are or would be available from Medicare, except for such health care services for which under applicable federal law this policy is the primary payer and Medicare is the secondary payer. Please also see section “Coverage with Medicare.”

Health care services for any illness or injury caused by any military-related act or incident of declared or undeclared war, riots, or insurrection.

Health care services for any illness or injury you sustain: (a) while on active duty in the armed services of any country; or (b) as a result of you being on active duty in the armed services of any country.

Custodial care or rest care.

Charges in excess of the maximum allowable fee or maximum out-of-network allowable fee.

General fitness programs, exercise programs, exercise equipment, and health club memberships.

Health care services for or related to gender reassignment surgery.

Health care services provided while held, detained, or imprisoned in a local, state or federal penal or correctional institution or while in custody of law enforcement officials, except as required under Wis. Stat. § 609.65. This exclusion does not apply to covered persons on work-release.

Completion of claim forms or forms necessary for the return to work or school.

An appointment you did not attend.

Telehealth, except as specifically stated in subsection “Medical Services.”

Health care services for which you have no obligation to pay or which are provided to you at no cost.

Health care services resulting or arising from complications of, or incidental to, any health care service not covered under this policy, except for complications of, or services incidental to, a covered person's or his/her spouse's elective abortion.

Health care services requested by a third party for employment, licensing, insurance, marriage, adoption, travel, disability determinations, or court-ordered exams, other than as specifically stated in this policy or required by law.

Cranial banding or orthotic helmets, unless required after cranial surgery.

Private duty nursing.

Marriage counseling.

Reversal of sterilization.

Transportation or other travel costs associated with a health care service, except as specifically provided in subsection “Ambulance Services.”

Bereavement counseling, unless provided as part of hospice coverage.

Health care services that are excluded elsewhere in this policy.

Health care services not specifically identified as being covered under this policy, except for those health care services approved by us subject to subsection “Alternative Care.”

Health care services provided in connection with a health care service not covered under this policy (e.g., inpatient hospital services related to gastric bypass surgery).

Health care services provided when your coverage was not effective under this policy. Please see section “When Coverage Ends.”

Health care services not provided by a physician or any of the health care providers listed in section “Covered Expenses.”

The following procedures and any related health care services: Injection of filling material (collagen) other than for incontinence; salabrasion; rhytidectomy (face lift); dermabrasion; chemical peel; suction-assisted lpectomy (liposuction); hair removal; mastopexy; mammoplasty, including augmentation or reduction mammoplasty (except for reconstruction associated with mastectomy);
Limitations & Exclusions
This plan does not cover the following services. Please see your policy for more specific information.

correction of inverted nipples; sclerotherapy for spider veins; pancreatectomy; mastectomy for male gynecomastia; botulinum toxin or similar products, unless you receive our prior authorization; any modification to the anatomic structure of a body part that does not affect its function; labioplasty; and treatment of sialorrhea (drooling or excessive salivation).

Health care services provided at any nursing facility or convalescent home or charges billed by any place that’s primarily for rest, for the aged or for drug abuse or alcoholism treatment, except as specifically stated in subsection “Behavioral Health Services.”

Health care services provided: (a) in the examination, treatment or removal of all or part of corns, callosities, hypertrophy or hyperplasia of the skin or subcutaneous tissues of the feet; (b) in the cutting or trimming of toenails; or (c) in the non-operative partial removal of toenails. This exclusion does not apply to such health care services which are associated with a medical diagnosis of diabetes, peripheral vascular disease or peripheral neuropathy.

Health education; complementary, alternative or holistic medicine; or other programs with an objective to provide personal fulfillment.

Health care services that you receive not for the treatment of your own illness or injury, but in connection with the treatment of collateral who is not a covered person under this policy.

Housekeeping, shopping, or meal preparation services.

Health care services provided in connection with: (a) any illness or injury caused by your engaging in an illegal occupation; or (b) any illness or injury caused by your commission of, or an attempt to commit, a felony.

Maintenance care or supportive care.

Health care services provided in connection with the temporomandibular joint or TMJ syndrome, except as specifically stated in subsection “Temporomandibular Joint Disorder (TMJ).”

Health care services for which proof of claim isn’t provided to us in accordance with subsection “Filing Claims.”

Health care services and prescription legend drugs provided in connection with alcoholism, drug abuse and nervous or mental disorders, except as specifically stated in the following subsections: (a) “Hospital Services” (limited to inpatient hospital services for detoxification of drug addiction or alcohol dependency); (b) “Behavioral Health Services;” (c) “Nutritional Counseling;” (d) “Prescription Legend Drugs and Supplies;;” and (e) “Skilled Nursing Care in a Skilled Nursing Facility.”

Health care services not for or related to an illness or injury, other than as specifically stated in this policy.

Sales tax or any other tax, levy, or assessment by any federal or state agency or a local political subdivision.

Costs associated with indirect services provided by health care providers such as: creating standards, procedures, and protocols; calibrating equipment; supervising the testing; setting up parameters for test results; reviewing quality assurance data; transporting lab specimens; physician concierge payments; translating claim forms or other records; and after-hours charges.

Treatment of weak, strained, flat, unstable or unbalanced feet; arch supports; heel wedges; lifts; orthopedic shoes; or the fitting of orthotics to aid walking or running; unless specifically stated otherwise in this policy.

Health care services for treatment of sexual dysfunction, including impotence, regardless of the cause of the dysfunction. This includes: (a) surgical services; (b) devices; (c) drugs for, or used in connection with, sexual dysfunction; (d) penile implants; (e) sex therapy; and (f) the treatment of Peyronie’s disease.

Health care services not supported by information contained in your medical records or from other relevant sources.

Health care services provided for your convenience or for the convenience of a physician, hospital, or other health care provider.

Baseline neuropsychological testing, for example, impact testing. Magnetic sphincter augmentation (Linx® System); transoral incisionless fundoplication procedures.

Health care services that are for purposes of educational, occupational or athletic enhancement.

Storage of blood tissue, cells, or any other body fluids.

Salivary hormone testing.

Non-emergency health care services performed while outside of the United States.

Prolotherapy.

Platelet-rich plasma.

Coma stimulation programs.

In lab polysomnogram (PSG), unless a home sleep study is determined by us to not be medically appropriate.

Cosmetic Treatment Exclusion
Health care services that we determine to be cosmetic treatment.

Drug Exclusions
Non-legend vitamins, minerals, and supplements even if prescribed by a physician, except as specifically stated in subsection “Prescription Legend Drugs.”

All enteral feedings, supplemental feedings, over-the-counter nutritional and electrolyte supplements, including infant formula.

Retinoids, Minoxidil, Rogaine, or their medical equivalent in the United States.

Dental Services Exclusions
The care and treatment of teeth, gums, or alveolar process including dentures, appliances, or supplies used in such care or treatment.
Limitations & Exclusions
This plan does not cover the following services. Please see your policy for more specific information.

Injuries or damage to teeth (natural or otherwise) that result from or are caused by the chewing of food or similar substances.
Dental implants or other implant related procedures, except as specifically stated in subsection “Dental Services.”
Orthognathic surgery or any surgical procedure performed to correct deformities of the mandible or maxilla, correction of malocclusion, or orthodontic treatment (e.g., braces), except as specifically stated in subsection “Dental Services.”
Tooth extraction of any kind, except as specifically stated in subsection “Dental Services.”

Durable Medical Equipment, Medical Supplies, and Prosthesis Exclusions
Modifications to your vehicle, home, or property including, but not limited to, escalators, elevators, saunas, steam baths, pools, hot tubs, whirlpools, tanning equipment, wheelchair lifts, stair lifts, chair lifts, grab bars, raised toilet seats, commodes, or ramps.
Medical supplies and durable medical equipment for your comfort, personal hygiene, or convenience, including, but not limited to, physical fitness equipment, physician’s equipment, disposable supplies (other than colostomy supplies, enteral therapy supplies, and/or urinary catheters and supplies), or self-help devices not medical in nature.
Environmental items including, but not limited to, air conditioners, air purifiers, humidifiers, dehumidifiers, furnace filters, heaters, vaporizers, or vacuum devices.
Wigs, toupees, hairpieces, cranial prosthesis, hair implants, or transplants or hair weavings.
Replacement of batteries and routine periodic maintenance of durable medical equipment, except for periodic maintenance for oxygen concentrators under a maintenance agreement which consists of one month rental billed every six months.
Rental fees for durable medical equipment that are more than the purchase price.
Durable medical equipment or prosthetics that we determine to have special features.
Continuous passive motion (CPM) devices and mechanical stretching devices.
Repairs due to abuse or misuse.
Home devices such as:
- Home spinal traction devices or standers; home INR (international normalized ration blood test) monitors; home phototherapy for dermatological conditions; home pneumatic compression devices for DVT (deep vein thrombosis) prevention; cold therapy (application of low temperatures for the skin) including, but not limited to, cold packs, ice packs, cryotherapy.
- Light boxes for behavioral health conditions.
- Car seats.

Genetic Counseling, Studies, and Testing Exclusions
Genetic counseling, studies, and testing other than the coverage that is specifically provided in subsection “Genetic Services.”
Genetic testing for the purposes of confirming a suspected diagnosis of a disorder that can be diagnosed based on clinical evaluations alone.
Genetic testing for conditions which cannot be altered by treatment or prevented by specific interventions.
Genetic testing solely for the purpose of informing the care or management of your family members.
Genetic counseling performed by the laboratory that performed the genetic test.

Hearing Services Exclusions
Augmentation communication devices and related instruction or therapy.
Hearing protection equipment.

Hospital Services Exclusion
Hospital stays if care could be provided in a less acute setting.

Infertility Exclusions
Health care services associated with expenses for infertility or fertility treatment, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to health care services required to treat or correct underlying causes of infertility.
Direct attempts to achieve pregnancy or increase chances of achieving pregnancy by any means.
Evaluation and treatment of habitual abortions (three consecutive documented spontaneous abortions in the first or second trimesters) when not pregnant.
Any laparoscopic procedure during which an ovum is manipulated for the purpose of fertility treatment even if the laparoscopic procedure includes other purposes.

Maternity Exclusions
Birthing classes, including Lamaze classes.
Home births.
Abortion procedures, except as specifically stated in subsection “Maternity Services.”

Reconstructive Surgery Exclusions
Reconstructive surgery, except as stated in subsection “Surgical Services.”

Rehabilitation/Rehabilitative Services Exclusions
Vocational or industrial rehabilitation, including work hardening programs.
Cardiac rehabilitation beyond Phase II.
Sports hardening and rehabilitation.
Health care services used in educational or vocational training or testing.
Limitations & Exclusions
This plan does not cover the following services. Please see your policy for more specific information.

Health clubs or health spas, aerobic and strength conditioning, functional capacity exams, physical performance testing, and all related material and products for these programs.

Long-term therapy and maintenance therapy.

**Therapy Exclusions**
Massage therapy or aquatic therapy, except as specifically stated in subsection “Therapy Services.”

Hypnosis.

Acupuncture therapy.

Health care services for holistic or homeopathic medicine or other programs that are not accepted medical practice, as determined by us, including, but not limited to, aromatherapy, herbal medicine, naturopathy, and reflexology.

Sex therapy.

Chelation therapy, except in the treatment of heavy metal poisoning.

Biofeedback, except for fecal/urinary incontinence.

Health care services by an athletic trainer.

Therapy services such as recreational therapy (other than recreational therapy included as part of a treatment program received during an inpatient hospital confinement for treatment of nervous or mental disorders, alcoholism, or drug abuse), educational therapy, physical fitness, or exercise programs, except as specifically stated in subsection “Cardiac Rehabilitation Services” and “Therapy Services.”

Photodynamic therapy and laser therapy for the treatment of acne.

**Transplant Exclusions**
Transplants considered by us to be experimental, investigational, or unproven.

Expenses related to the purchase of any organ.

Health care services for, or used in connection with, transplants of human and non-human body parts, tissues or substances, implants of artificial or natural organs or any complications of such transplants or implants, except as specifically stated in subsection “Transplants.”

Lodging expenses, including meals, unless such expenses are covered under the global fee agreement of your transplant network.

**Vision Services Exclusions**
Vision therapy;
Orthoptic therapy and pleoptic therapy (eye exercise);
Preparation, fitting, or purchase of eye glasses or contact lenses, except as specifically stated in this policy;
Correction of visual acuity or refractive errors by any means, except as specifically stated in this policy;
Implantable accommodating lenses to improve vision following cataract surgery; and
Replacement lenses, frames, or contact lenses due to loss, theft, or damage.

**Weight Control Exclusions**
Health care services provided in connection with a diagnosis of obesity, morbid obesity, weight control, or weight reduction, regardless of whether such services are prescribed by a physician or associated with an illness or injury.

Services excluded under this provision include, but are not limited to:

- Gastric or intestinal bypasses; gastric balloons or banding;
- Stomach stapling; wiring of the jaw; liposuction; drugs; weight loss programs, unless benefits are provided elsewhere in this policy;
- Physical fitness or exercise programs or equipment, unless benefits are provided elsewhere in this policy; and
- Bone densitometry (DEXA, DXA) scans.

**Preventive/Wellness Care Exclusions**
Any immunization or vaccination provided by a non-participating provider. (HMO product only).

Immunizations for travel purposes.