Exclusions & Limitations

We will not provide a Benefit for any of the items listed in this section regardless of Medical Necessity or recommendation of a health care provider.

(1) Treatment, services and supplies which are not related to a specific diagnosis, acute symptoms or course of treatment; medical care or surgery which is not Medically Necessary; and any maintenance type therapy not reasonably expected to improve a Covered Person's condition.

(2) Pre-employment or pre-marital examinations; or routine physical examinations.

(3) Treatment, services and supplies for Experimental or Investigational procedures, including Experimental or Investigational organ transplant procedures, drugs or treatment methods.

(4) Treatment, services and supplies for which the Covered Person is not legally required to pay.

(5) Telephone consultations, failure to keep scheduled appointments, completion of claim forms, or providing medical information necessary to determine coverage.

(6) Treatment, services and supplies provided by a Close Relative.

(7) Treatment, services and supplies provided outside the scope of the license for the institution or practitioner rendering services.

(8) Education, training, or bed and board while confined to an institution which is primarily a school or other institution for training, a place of rest or a place for the aged, or a personal residence.

(9) Treatment, services or supplies received prior to the Covered Person's Effective Date, or after the end of the Coverage Period.

(10) Inpatient Hospital admission occurring on a Friday or Saturday in conjunction with a surgical procedure scheduled to be performed during the following week. A Sunday admission will be eligible only for the procedure scheduled to be performed early Monday morning. (This limitation will not apply to necessary medical admissions requiring immediate attention or to Emergency surgical admissions).

(11) Amounts in excess of the Usual, Reasonable and Customary charges made for Covered Expenses.

(12) Surgery for a Covered Person for a total or partial hysterectomy, unless it is Medically Necessary due to a diagnosis of carcinoma (subject to all other coverage provisions, including but not limited to the Pre-Existing Condition exclusion); tonsillectomy, adenoidectomy, repair of deviated nasal septum or any type of surgery involving the sinus, myringotomy, tympanotomy, or herniorrhaphy.

(13) Outpatient Prescription Drugs, contraceptive drugs and devices, non-prescription drugs, vitamins, minerals and nutritional supplements.

(14) Cosmetic Surgery.

(15) Infertility and impregnation procedures, such as but not limited to, artificial insemination, in-vitro fertilization, embryo and fetal implantation and G.I.F.T. (gamete intrafallopian transfer).

(16) Pregnancy and related services; except for Complications of Pregnancy.

(17) Voluntary termination of pregnancy.

(18) Voluntary sterilization or reversal thereof.

(19) Custodial Care.

(20) Dental services.

(21) Routine foot care.

(22) Speech Therapy.

(23) Mental or Nervous Disorders.

(24) Substance Use Disorders.

(25) Treatment, services, or supplies for obesity, extreme obesity, morbid obesity or weight reduction, including, but not limited to, wiring of the teeth and all forms of surgery including, but not limited to, bariatric surgery, intestinal bypass surgery and complications resulting from any such surgery.

(26) Programs, treatment or procedures for tobacco use cessation.

(27) Treatment of acne or varicose veins.

(28) Diagnosis or treatment of a sleeping disorder.

(29) Allergy testing and allergy injections.

(30) Diabetic Equipment, Supplies and Self-Management training.

(31) Autism Spectrum Disorder.

(32) Therapy or treatment for learning disorders or disabilities or developmental delays.

(33) Participation in Clinical Trials.

(34) Prosthetic and Orthotic Devices; except as specifically covered in Section 4 - Benefits.

(35) Homeopathy.

(36) Orthopedic Manipulation.

(37) Private duty nursing services.

(38) Acupuncture and Acupressure.

(39) Genetic testing or counseling including, but not limited to, amniocentesis and chorionic villi testing.

(40) Sex transformation; treatment of sexual function, dysfunction or inadequacy; or treatment to enhance sexual performance or desire.

(41) Treatment to stimulate growth and growth hormones for any purpose.

(42) Eye examinations, eyeglasses, or contact lenses to correct refractive errors and related services including surgery performed to eliminate the need for eyeglasses, for refractive errors such as radial keratotomy or keratoplasty.

(43) Hearing exams, hearing aids, or the fitting of hearing aids.

(44) Treatment for cataracts.

(45) Orthoptics and visual eye training.

(46) Treatment, services and supplies for a Covered Dependent who is a newborn child not yet discharged from the Hospital. This does not apply to charges that are Medically Necessary to treat premature birth, congenital Injury or Illness, or Illness or Injury sustained during or after birth.

(47) Personal comfort or convenience items, including homemaker services or supportive services focusing on activities of daily life that do not require the skills of qualified technical or professional personnel, including but not limited to bathing, dressing, feeding, routine skin care, bladder care and administration of oral medications or eye drops.

Exclusions & Limitations (Continued)

(48) The purchase of a noninvasive osteogenesis stimulator (bone stimulator).

(49) Services or supplies of a common household use, such as exercise cycles, air or water purifiers, air conditioners, allergenic mattresses, and blood pressure kits.

(50) Enrollment in health, athletic or similar clubs.

(51) Weight loss, non-smoking, exercise or similar programs.

(52) Recreational or educational therapy, or non-medical self-care or self-help training, nutritional counseling, marriage, family or goal-oriented counseling.

(53) Travel or transportation rendered by any person or entity other than professional ground or Air Ambulance.

(54) Care in government institutions unless a Covered Person is obligated to pay for such care.

(55) Treatment, services and supplies rendered to a Covered Person while on active duty in the armed forces. Upon written notice to Us of entry into such active duty, the unused premium will be returned to You on a pro rata basis.

(56) Treatment, services and supplies received outside of the United States or its possessions.

(57) Treatment, services and supplies for an Injury caused by an accident that arises out of or in the course of employment or for which the Covered Person is entitled to benefits under any Worker's Compensation Law, Occupational Disease Law or similar legislation.

(58) Illness or Injury that results from war or an act of war, (whether declared or undeclared) while serving in the military or an auxiliary unit attached to the military.

(59) Illness or Injury that results from participation in a riot or insurrection.

(60) Illness or Injury that results from commission or attempted commission of a felony or to which a contributing cause was the Covered Person being engaged in an illegal occupation.

(61) Complications resulting from treatment of conditions which are not covered under the Policy.

(62) Suicide or attempted suicide or intentionally self-inflicted Injury, whether while sane or insane.

(63) Injuries from participating in organized competitive sports.

(64) Treatment, services and supplies resulting from participation in skydiving, scuba diving, hand or ultra-light gliding, ballooning, bungee jumping, parakiting, riding an all-terrain vehicle such as a dirt bike, snowmobile or go-cart, racing with a motorcycle, motor vehicle, boat or any form of aircraft, any participation in sports for pay or profit, or participation in rodeo contests.

(65) Treatment or services required due to Accidental Injury sustained while operating a motor vehicle where the Covered Person's blood alcohol level, as defined by law, exceeds that level permitted by law or otherwise violates legal standards for a person operating a motor vehicle in the state where the Injury occurred.

Disclaimer: This is a brief description of the ThriveHealth Short Term Medical plan. Limitations, exclusions, terms and conditions may be different where required by state law. Please check the product certificate or master policy for complete details on benefits, limitations, and exclusions.

Exclusions for Pre-existing Conditions

Benefits are not payable for Pre-Existing Conditions. A Pre-Existing Condition means a condition:

1. for which medical advice, diagnosis, care, or treatment (includes receiving services and supplies, Consultations, diagnostic tests or prescription medicines) was recommended or received from a Physician within the 36 months immediately preceding the Covered Person's Effective Date; or
2. that had manifested itself in such a manner that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment (includes receiving services and supplies, Consultations, diagnostic tests or prescription medicines) within the 36 months immediately preceding such person's Effective Date.

This provision does not apply to a newborn or newly adopted child or child placed for adoption under the age of 18 if such child is enrolled for coverage within 31 days from the date of birth or the date of adoption or placement for adoption.

Waiting Period for Illness

Covered Persons will only receive Benefits for Illnesses that begin, by occurrence of symptoms and/or receipt of treatment, more than 5 days following the Covered Person's Coverage Effective Date.

Covered Persons will only receive Benefits for cancer that begins, by occurrence of symptoms and/or receipt of treatment, more than 30 days following the Covered Person's Coverage Effective Date.

There is no waiting period for Injuries.

Pre-Authorization

(1) All Inpatient Hospitalizations and procedures done at an Outpatient Surgical Facility must be pre-authorized.

(2) To comply with the pre-authorization requirements, the Covered Person must:

a) Contact the professional review organization at the following telephone number (866) 790-4177 as soon as possible before the expense is to be incurred; and

b) Comply with the instructions of the professional review organization and submit any information or documents they require; and

c) Notify all providers that this coverage contains pre-authorization requirements and ask them to fully cooperate with the professional review organization.

(3) If the Covered Person complies with the pre-authorization requirements, and the expenses are pre- authorized, the Company will pay Covered Expenses subject to all terms, conditions, provisions, limitations and exclusions described herein.

(4) If the Covered Person does not comply with the pre- authorization requirements, or if the expenses are not pre-authorization, Eligible Expenses will be reduced by 50%.

(5) Emergency pre-authorization: In the event of an Emergency Medical Condition, pre-authorization must be made when the patient is Stabilized.

(6) Pre-authorization does not guarantee benefits – The fact that expenses are pre-authorized does not guarantee payment of benefits. Benefits are subject to all the terms, conditions, provisions and exclusions herein.