Section 12: Exclusions – Things We Don't Cover

This section contains information about Medical services that are not covered. We call these Exclusions. It is important for You to know what services and supplies are not covered under this Policy.

We do not pay Benefits for exclusions or any related complications.

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if any of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for Your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in Section 11 (Covered Benefits) or through a Rider to this Policy.

Category	Description
A. Alternative Treatments	We do not cover alternative treatments, including but not limited to: 1. Acupressure and Acupuncture. 2. Aromatherapy. 3. Hypnotism. 4. Massage Therapy. 5. Rolfing. 6. Herbal remedies. 7. Ayurvedic therapies. 8. Reflexology. 9. Biofeedback and neurofeedback therapy. 10. Other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
B. Chiropractic	Spinal treatment and Chiropractic Care including: 1. Service and supplies for analysis and adjustment of spinal subluxation. 2. Diagnosis and treatment by any means (except treatment of fractures and dislocations of the extremities).
C. Comfort or Convenience	1. Television. 2. Telephone. 3. Beauty/Barber service. 4. Guest service. 5. Automated travel devices (motor scooters). 6. Supplies, equipment and similar incidental services and supplies for personal comfort or convenience. Examples include: - Air conditioners - Air purifiers and filters - Batteries and battery chargers - Dehumidifiers and Humidifiers - Electrostatic machines - Lights/lighting - Portable room heaters, grab bars, etc. - Vaporizers - Tanning booths - Bath chairs - Breast pumps, unless newborn in NICU - Exercise equipment - Raised or regular toilet seats - Whirlpools, saunas, and hot tubs 7. Devices and computers to assist in communication and speech. Augmentative communication devices, including but not limited to computer assisted speech devices, speech teaching machines, telephones, TDD equipment, Braille teaching texts, computers, and telephone alert systems. Exceptions include basic, Non-digital voice systems, such as the Electro-Larynx, after post-radical neck or other invasive surgery that interferes with laryngeal function. 8. Personal hygiene items and hygienic items, including but not limited to shower chairs,

Category	Description
	commodes (unless the individual is confined to room or bed), incontinence pads, bed baths, etc. 9. Devices that are primarily non-medical in nature or used primarily for comfort, including but not limited to: - Bed boards - Elevators - Foam pads - Heating pads - Beds other than standard single hospital beds - Carafes - Emesis basins - Maternity belts - Bathtub seats - Standing tables - Overbed tables 10. Chair lifts, bathtub lifts, bed lifter, and other similar devices. 11. Exercise equipment including but not limited to parallel bars, weights, bicycles, rowing machines, and treadmills.
D. Dental	1. Dental care except as described in Section 11 (Covered Benefits) under the heading, *"Dental Services Accident Only"* and *"Dental – Anesthesia and Facility Charges"*. 2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums, whether the services are considered to be medical or dental in nature. Examples include all of the following: – Extraction, restoration and replacement of teeth; – Medical or surgical treatments of dental conditions; – Services to improve dental clinical outcomes; – Services for overbite or underbite; – Services related to surgery for cutting through the lower or upper jaw bone; – Maxillary and mandibulary osteotomies. 3. Dental implants and associated oral surgery and supplies, even if associated with Accidental Dental Services. This includes but is not limited to any enabling procedures for implants, as well as placement, maintenance, restoration, and removal of dental implants. Any prosthetic superstructure fabricated upon a dental implant is also excluded. 4. Dental braces and occlusal splints, even if associated with Accidental Dental Services. 5. Dental x-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia. The only exceptions to this are for any of the following: – TransPlant preparation; – Initiation of immunosuppressives; – The direct treatment of acute traumatic Injury; – The direct treatment of cancer (i.e., injury to teeth as a direct effect of cancer treatment); – Cleft palate; – Covered Persons with conditions outlined in Section 11 (Covered Benefits) under Dental – Anesthesia and Facility Charges. 6. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a Congenital Anomaly, except with respect to newborns. 7. Orthodontic services. 8. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature. 9. Upper and lower jawbone surgery except as required for direct treatment of acute traumatic injury or cancer. 10. Orthognathic surgery, jaw alignment and treatment for the temporomandibular joint syndrome, except as a treatment of obstructive sleep apnea.

Category	Description
E. Drugs	1. Prescription drug products for outpatient use (including self-injectables) that are filled by a prescription order or refill. 2. Non-injectable medications given in a Physician's office except as required in an Emergency. 3. Over the counter drugs and treatments. 4. Charges for supplies for use beyond the first twenty-four (24) hours following discharge from the Hospital as an Inpatient or following the provision of Emergency Care, including any prescription drugs intended primarily for home use.
F. Experimental, Investigational or Unproven Services	1. Experimental, Investigational or Unproven Services are excluded. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
G. Foot Care	1. Routine foot care (including the cutting or removal of corns and calluses). 2. Nail trimming, cutting, or debriding, unless the charges are for the removal of a nail or root in connection with the treatment of a metabolic or peripheral-vascular disease or infection. 3. Hygienic and preventive maintenance foot care. Examples include the following: – Cleaning and soaking the feet; – Applying skin creams in order to maintain skin tone; – Other services that are performed when there is not a localized illness, Injury or symptom involving the foot. 4. Treatment of flat feet, painful feet, fallen arches, metatarsalgia, Plantar fasciitis, neuromas, tendonitis, bursitis, varus or valgus deformities, and other conditions of the feet unless otherwise noted in this document. 5. Treatment of subluxation of the foot. 6. Shoe orthotics, orthopedic shoes and other supportive appliances for feet except as otherwise noted in this document.
H. Medical Supplies and Appliances	1. Devices used specifically as safety items or to affect performance in sports-related activities. 2. Prescribed or Non-prescribed medical supplies and disposable supplies. Examples include: – Elastic stockings – Ace bandages – Gauze and dressings – Disposable sheets and bags – Fabric supports – Surgical face masks – Incontinent pads, including diapers – Irrigating kits – Pressure leotards – Surgical leggings and support hose Exceptions include diabetic supplies covered under the medical benefit and ostomy supplies, and supplies associated with equipment and home care services that have been provided in accordance with Plan policies and procedures. 3. Orthotic and prosthetic appliances for sports-related activities. 4. Tubings and masks are not covered except when used with Durable Medical Equipment as described in Section 11 (Covered Benefits). 5. Devices and equipment that are not normally appropriate outside of a hospital (or other provider) setting, including but not limited to: – Home monitoring devices and supplies, except Medically Necessary cardiac monitoring devices (such as holter monitors and event recorders) – Home prenatal monitoring and associated nursing support 6. The following are excluded under the medical benefit, only if MHP pharmacy benefit coverage is available: – Insulin syringes with needles

Category	Description
	– Lancets and lancet devices – Glucometers, test strips and related supplies 7. Lift Seats.
I. Mental Health/Substance Abuse	1. Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. 2. Services utilizing methadone treatment as maintenance, L.A.A.M (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents. 3. Psychosurgery. 4. Vagus nerve stimulation (VNS) for depression. 5. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements unless medically necessary and authorized by the Mental Health/Substance Abuse Designee. Medically Necessary care may include any of the following: a. Not consistent with prevailing national standards of clinical practice for the treatment of such conditions including but not limited to Mental Health Services and Substance Abuse Services that extend beyond the period necessary for short term evaluation, diagnosis, treatment or crisis intervention; b. Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome; c. Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective; d. Not consistent with the Mental Health/Substance Abuse Designee's level of care guidelines or best practices as modified from time to time. 6. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance abuse disorders that, in the reasonable judgment of the Mental Health/Substance Abuse Designee, are any of the following: a. Not consistent with prevailing national standards of clinical practice for the treatment of such conditions including but not limited to Mental Health Services and Substance Abuse Services that extend beyond the period necessary for short term evaluation, diagnosis, treatment or crisis intervention; b. Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome; c. Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective; d. Not consistent with the Mental Health/Substance Abuse Designee's level of care guidelines or best practices as modified from time to time. The Mental Health/Substance Abuse Designee may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.
J. Nutrition	1. Megavitamin and nutrition based therapy (for any purpose). 2. Vitamins (other than those prenatal vitamins prescribed for a Member who is then pregnant). 3. Nutritional counseling and other hospital-based educational programs for either individuals or groups, except for treatment of Diabetes or certain illnesses or conditions. 4. Medical foods and other nutritional and electrolyte supplements taken orally or enterally regardless of the disease state, including infant formula and donor breast milk. This exclusion does not apply to the treatment of Phenylketonuria or any inherited disease of amino or organic acids, or nutritional supplements ordered by a Physician in connection with home care, which requires the Member to have a feeding tube as a sole source of nutrition.
K. Personal	1. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under this Policy when: a. Required solely for purposes of career, education, sports or camp, travel,

Category	Description
	recreation, employment, insurance, marriage or adoption; b. Related to judicial or administrative proceedings or orders; c. Conducted for purposes of medical research; d. Required to obtain or maintain a license of any type. 2. Custodial Care. See Section 13 (Definitions of Terms). 3. Domiciliary care or any nursing care on full-time basis in Your home. 4. Private Duty Nursing. See Section 13 (Definitions of Terms). 5. Respite care. 6. Rest cures. 7. Medical and surgical treatment of excessive sweating (hyperhidrosis). 8. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. 9. Oral appliances for snoring. 10. Care for an Injury or Illness resulting from participation in, or in consequence of having participated in an illegal occupation or the commission of an assault or felony. 11. Work place evaluations and work hardening treatment.
L. Physical Appearance	1. Cosmetic Procedures. See the definition in Section 13 (Definitions of Terms). Examples include: – Pharmacological regimens, nutritional procedures or treatments; – Scar, keloid or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures); – Skin abrasion procedures performed as a treatment for acne; – Liposuction; – Hair transPlant for baldness; – Correction of asymmetric breasts or abnormal nipple-areolar complexes and protruding ears; – All other cosmetic services **except** if medically necessary to: i. Repair a functional disorder caused by a disease or an accidental injury suffered while insured by the Plan; ii. Restore or improve function for a structurally abnormal Congenital or developmental defect or anomaly in a Member under age nineteen (19). Anomaly is defined as a marked deviation beyond the range of normal human variation; or iii. Reconstructive breast surgery performed post-mastectomy; 2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. 3. Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation. 4. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded. 5. Wigs, regardless of the reason for the hair loss, except as otherwise provided by law. 6. Treatment of benign gynecomastia (abnormal breast enlargement in males). 7. Surgical and Non-surgical treatment of obesity, including morbid obesity. Treatment includes but is not limited to, stomach stapling, jaw wiring, gastric banding, gastric balloon or bypass surgery, dietary/nutritional supplements, behavioral/community support programs, exercise programs, and medical testing, medications, and office visits associated with any weight loss program. 8. Growth hormone except as determined Medically Necessary by the Plan to treat diagnostically proven growth hormone deficiency. Growth hormone(s) to treat idiopathic short stature (ISS) is expressly excluded. 9. Sex transformation operations. 10. Breast Reduction Surgery (Reduction Mammoplasty).

Category	Description
M. Preexisting Conditions	Benefits for the treatment of a Preexisting Condition are excluded until the date You have been covered under this Policy for a period of twelve (12) months, except this waiting period will not apply to: a. A child who is placed in a Member's physical custody for purpose of adoption if the petition for adoption is filed within thirty (30) days of placement of such a child; or, b. A person who has had creditable coverage for 18 months without a break of sixty-three (63) days or more.
N. Providers	1. Services performed by a provider who is a family member by birth or marriage, including Spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. 2. Services performed by a provider with Your same legal residence. 3. Services provided at a freestanding or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services that are self-directed to a free-standing or Hospital based diagnostic facility. Services ordered by a Physician or other provider who *is* an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider: a. Has not been actively involved in Your medical care prior to ordering the service, or b. Is not actively involved in Your medical care after the service is received. This exclusion does not apply to mammography testing. 4. Charges Incurred for broken appointments with a Participating Physician.
O. Reproduction	1. Health services and associated expenses for Infertility treatments including, but not limited to, medical care or prescription drugs used to stimulate ovulation, or assisted reproductive technology (ART). ART includes any combination of chemical and/or mechanical means of obtaining a mature male or female reproductive cell and placing it into a medium (whether internal or external to the human body) to enhance the chance reproduction will occur. Examples of ART include, but are not limited to, artificial insemination, in vitro fertilization, gametic intra fallopian transfer, zygote intra fallopian transfer, pronuclear state tubal transfer and surrogate Pregnancy. 2. Surrogate parenting. 3. Voluntary sterilization or the reversal of voluntary sterilization. 4. Health services and associated expenses for elective abortion. Elective abortion means an abortion for any reason other than a spontaneous abortion or loss of the fetus as a result of the only treatment available to save the life of the mother. 5. Contraceptive supplies and services. 6. Fetal reduction surgery. 7. Health services associated with the use of non-surgical or drug induced Pregnancy termination. 8. Services (including pharmaceuticals) provided in connection with treatment or surgery to change gender or restore sexual function, unless otherwise covered in this Policy. 9. Maternity Services, unless superseded by a Rider. Complications of Pregnancy, however, are covered.

Category	Description
P. Services Provided under Another Plan	1. Health service for which other coverage is required by Federal, state or local law to be purchased or provided through other arrangements. 2. Health services for treatment of Injury, Sickness or Mental Illness arising out of or in the course of, any employment, whether or not covered by Workers' Compensation or similar law. If coverage under Workers' Compensation or similar legislation is optional for You because You could elect it, or could have it elected for You, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under Workers' Compensation or similar legislation if that coverage had been elected. 3. Health services for treatment of military service-related disabilities, when You are legally entitled to other coverage and facilities are reasonably available to You. 4. Health services while on active military duty. Upon notifying Mercy Health Plans of entry into military service, any pro-rata unearned premiums shall be refunded. 5. Injury or Illness incurred while incarcerated in any local, municipal, state or Federal facility.
Q. Therapies/Psychological Testing	1. Speech, physical, occupational, and other rehabilitative services solely for speech/language delay or articulation disorders or other developmental delay, regardless of origin (unless otherwise covered under this Policy, or by law). Speech Therapy for central processing disorders, dyslexia, attention deficit disorder or other learning disabilities, stammering, stuttering, conceptual handicap, psychosocial speech delay, and voice therapy for vocational or avocational singers, and procedures that may be carried out effectively by the patient, family, or caregivers are not covered Benefits. Speech, physical, occupational, and other rehabilitative services are not covered except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, or a Congenital Anomaly. 2. Cognitive therapy as a medical treatment (non-mental health) unless provided for acute brain injury. 3. Psychological testing for services that are considered primarily educational or training in nature or related to improving academic or work performance, except when authorized in advance by the Mental Health/Substance Abuse designee. 4. Neuropsychological Testing to assist in Planning educational, training, and vocational programs, for the purpose of disability determinations, and/or for forensic determinations including Neuropsychological Testing for any of the following diagnosis, except as otherwise provided by law i. Attention-deficit/hyperactivity disorder (ADHD) ii. Developmental disability, developmental delay iii. Learning disability iv. Mental retardation v. Tourette's syndrome vi. Autism Spectrum Disorder 5. All Educational Services, including treatment of learning disorders and acquired cognitive deficits. 6. Water exercise and other exercises not under the supervision of a physical therapist. 7. Services or supplies that cannot reasonably be expected to lessen a Member's disability, and enable him/her to live outside an institution. 8. Therapy for conditions such as developmental delay, ADHD, and autism.
R. Transplants	1. Health services for organ and tissue transplants, except those described in Section 11 (Covered Benefits). 2. Health services connected with the removal of an organ or tissue from You for purposes of a transPlant to another person. (Donor costs for removal are payable for a transPlant through the organ recipient's Benefits under this Policy). 3. Health services for transplants involving mechanical or animal organs. 4. Any multiple organ transPlant not listed as a Covered Health Service under the heading *TransPlantation Health Services* in Section 11 (Covered Benefits).

Category	Description
S. Travel	1. Health services provided in a foreign country, unless required as Emergency Health Services. 2. Travel or transportation expenses, even though prescribed by a Physician, except for medically necessary ambulance services. Some travel expenses related to covered transPlantation services may be reimbursed at Our direction. 3. Air Ambulance Services outside the continental United States for any reason.
T. Vision and Hearing	1. Purchase cost of eye glasses, contact lenses (except for eyeglasses or contact lenses prescribed following cataract surgery, up to a maximum of a $300.00 dollar benefit per lifetime), or hearing aids. 2. Fitting charge for hearing aids, eye glasses or contact lenses. 3. Eye exercise therapy (orthoptics or pleoptic training). 4. Surgery that is intended to allow You to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.
U. General/ Administrative	1. Health services and supplies that are not included in Section 11 (Covered Benefits), or that do not meet the definition of a Covered Health Service - see the definition in Section 13 (Definitions of Terms). 2. Health services received as a result of any catastrophic act or incident of war, whether declared or undeclared or caused during service in the armed forces of any country. 3. Health services received after the date Your coverage under this Policy ends, including health services for medical conditions arising before the date Your coverage under his Policy ends. 4. Health services for which You have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Policy. 5. Charges in excess of the Usual and Customary Rate (UCR) or in excess of any specified limitation. 6. Complications of Health Care Services that are not Covered Health Services, except for Complications of Pregnancy. 7. Charges made for completion of forms and/or filing of claims in connection with the Benefits provided under this Plan. 8. Autopsies (post-mortem exams).