Health Solutions Elite Health Plus
2025 Schedule of Medical Benefits

If the service is not listed on the Schedule of Benefits, it is not covered.

PPO Provider Network:
First Health as primary with a Multiplan Network as secondary
Out-of-Network Providers:
Not Covered

***D - PreCertification**

***Precertification is required. Failure to obtain preauthorization will result in a denial of beniefits.**

***Precertification is required for any service or procedure over $2,500 except on Prevetative Benefits and Emergency Room.**

All services must be deemed medically necessary.

Coverage ends the last day of the month in which the termination occurred.

Preventive Service Benefits are based on a Plan Year. Out of Country Care is not covered.

Rural Area is difined as 30 miles. If preventive services are not available within 30 miles of your residence the provider will be paid in network.

Note: Any non-allowed or not covered amounts or services are the responsibility of the patient and not included in the Out-of-Pocket Maximum.

Dependents covered to age 26 regardless of student or marital status.

Timely Filing: Medical Claims must be filed within 120 days from the date the service incurred.

Any person that is eligible for Medicare is not eligible for this plan.

No benefits for preventive services performed at a hospital.

12 month pre-existing condition limit applies to Labor and Delivery benefits. A pregnancy that started prior to enrollment is subject to these limits.

If the service is not listed on the Schedule of Benefits, it is not covered.

Lifetime Max: None	**Network Providers**	**Out-of-Network Providers**	**Benefit Limits Per Plan Year**
Annual Deductibles Does not include Co-pays.	Individual: $1,000 Family: $2,000	None	**Limits are per person per Calendar Year.** **Beginning January 1 and ending December 31.** **All limits and accumulations are per person per plan year.**
Annual Co-Insurance **Out of Pocket Maximums** (Includes deductible and Medical co-pays and co-insurance)	None	None	
Office Visits - Primary Care (exams or consultations)	$35 Copay, then Plan pays 100% of the PPO Amount	No Benefit	
Office Visits - Specialist (exams or consultations)	$75 Copay, then Plan pays 100% of the PPO Amount	No Benefit	**Includes Maternity Prenatal, Mental Health & Substance Abuse.**
Telemedicine	$0 Copay		Only through plan provided benefit program.
Diagnostic Services - Basic Radiology In-Office (related to office visit, LabCorp, etc)	$50 Copay per image billed, then Plan pays 100% of the PPO Amount	No Benefit	Co-pay is per image billed. **No Benefits for services provided in a hospital**
Diagnostic Services - Basic Labs In-Office (related to office visit, LabCorp, etc)	$100 Copay per visit, then Plan pays 100% of the PPO Amount	No Benefit	Co-pay is per visit. **No Benefits for services provided in a hospital**
Diagnostic Services - Major ***D** (MRI, CT, PET, Nuclear Medicine, etc.)	$500 Copay, then Plan pays 100% of the PPO Amount	No Benefit	Co-pay is per image billed. **No Benefits for services provided in a hospital**
Diagnostic Services - Minor (ultrasound, bone density, echography, etc)	$50 Copay, then Plan pays 100% of the PPO Amount	No Benefit	Co-pay is per image billed. **No Benefits for services provided in a hospital**
Emergency Room - Facility	Deductible, then $400 Copay, then Plan pays 50% of Allowed Amount		Limited to 1 visit per Calender Year. Coverage is limited to emergent services only.

***D** Hospital - Inpatient Services **Room & Board Charges ONLY**	Deductible, then $500 Copay, then Plan pays 40% of Allowed Amount	No Benefit	Room & Board only. Limited to 5 days per Calendar Year. Includes Mental Health & Substance Abuse. Covers Childbirth/Delivery.
***D** Maternity - Facility & Physicians	Deductible, then $500 Copay, then Plan pays 40% of Allowed Amount	No Benefit	Limited to 5 days combined with Mental Health, Substance Abuse, and Hospitilization per person per plan year. Pre-Authorization required for stays longer than 48/98 hours. 12 month pre-existing limit condition applies to benefits.
Urgent Care Center & 24 Hours	$150 Copay, then Plan pays 100% of the PPO Amount	$150 Copay, then Plan pays 100% of the PPO Amount	

Covered Preventive Services for Adults as defined by CMS Preventive Services			
Wellness Office Visits and Lab Services	**Network Providers**	**Out-of-Network Providers**	**Benefit Limits**
Office Visit Exam & Includes Services For:	Plan pays 100%	No Benefit	Limited to preventive diagnosis only.
Abdominal Aortic Aneurysm	Plan pays 100%	No Benefit	One time screening for males of ages 65 to 75 who have ever smoked.
Alcohol Misuse Screening and Counseling	Plan pays 100%	No Benefit	
Aspirin use for Men and Women	Plan pays 100%	No Benefit	A low-dose aspirin for prevention of cardiovascular disease and colorectal cancer in adults aged 45-59 years. (See plan document for further criteria.)
Blood Pressure Screening	Plan pays 100%	No Benefit	One screening every two years for ages 18 to 39. One Screening per plan year for ages 40 and over.
Cholesterol Screening	Plan pays 100%	No Benefit	One screening per plan year for men 35 and older. Men under 35 who have heart disease or risk factors for heart disease or women who have heart disease or risk factors for heart disease.
Colorectal Cancer Screening	Plan pays 100%	No Benefit	Screening for adults over age 45. **No Benefits for services provided in a hospital.**
Depression Screening	Plan pays 100%	No Benefit	Screening for depression in the general adult population, including pregnant and postpartum women.
Type 2 Diabetes Screening	Plan pays 100%	No Benefit	Screening for adults with high blood pressure only.
Diet Counseling	Plan pays 100%	No Benefit	Screening for adults at higher risk of chronic disease.
Hepatitis B Screening	Plan pays 100%	No Benefit	For members at high risk, including members in countries with 2% or more Hepatitis B prevalence, and US born people not vaccinated as infants & with at least one parent born in a region with 8% or more Hepatitis B prevalence.
Hepatitis C Screening	Plan pays 100%	No Benefit	For adults at increased risk, and one time for everyone born between 1945 - 1965.
HIV Screening	Plan pays 100%	No Benefit	Screening for adults at higher risk.
Immunizations *Hepatitis A *Hepatitis B *Herpes Zoster *Human Papillomavirus *Influenza (Flu Shot) * Measles, Mumps, Rubella *Meningococcal *Pneumococcal *Tetanus, Diphtheria, Pertussis *Varicella	Plan pays 100%	No Benefit	Listed immunizations are once per Calendar year. Human Papillomavirus shots up to age 26. Pneumococcal shots for adults 65 and older.
Latent Tuberculosis Infection	Plan pays 100%	No Benefit	Screening for latent tuberculosis infection (LTBI) in populations at increased risk.
Lung Cancer Screening	Plan pays 100%	No Benefit	For adults 55-80 at high risk for lung cancer because they are heavy smokers or have quit in the past 15 years.

Obesity Screening and Counseling	Plan pays 100%	No Benefit	
Sexually Transmitted Infection (STI) Screening and Counseling	Plan pays 100%	No Benefit	Prevention counseling for adults at higher risk. Includes syphilis screening.
Statin	Plan pays 100%	No Benefit	Adults aged 40-75 years with no history of cardiovascular disease (CVD) use a low to moderate dose statin for the prevention of CVD events and mortality when they have one or more cardiovascular disease risk factors, and a calculated 10-year CVD event risk of 10% or greater, screening for cardiac risk may include assessment of blood pressure, smoking status, screening for lipid disorders and use of ACC/AHA CVD to estimate 10 year risk.
Syphilis Screening	Plan pays 100%	No Benefit	For all adults at higher risk.
Tobacco Use Screening	Plan pays 100%	No Benefit	Screenings for adults and cessation interventions for tobacco users.
Covered Preventive Services for Women - Including Pregnant Women			
Wellness Office Visits and Lab Services	**Network Providers**	**Out-of-Network Providers**	**Benefit Limits**
Well-Women Visits	Plan pays 100%	No Benefit	
Anemia Screening	Plan pays 100%	No Benefit	For pregnant women.
***D** BRCA Counseling	Plan pays 100%	No Benefit	Includes genetic test for women at high risk. **No Benefits for services provided in a hospital.**
Breast Cancer Mammography Screening	Plan pays 100%	No Benefit	Screenings every 1 to 2 years for women over 40 through age 74. (See plan document for further criteria) **No Benefits for services provided in a hospital.**
Breast Cancer Chemoprevention Counseling	Plan pays 100%	No Benefit	Counseling for women at high risk.
Breast Pumps	Plan pays 100%		One per delivery. Purchase Breast Pump at a local retail store and submit the receipt for reimbursement.
Breastfeeding Consultations	Plan pays 100%	No Benefit	Providing interventions during pregnancy and after birth to support breastfeeding. Comprehensive support and counseling from trained providers as well as access to breastfeeding supplies for pregnant and nursing women.
Cervical Cancer Screening	Plan pays 100%	No Benefit	For ages 21-29, PAP smear every 3 years. For ages 30-65, with cytology and human papillomavirus testing (HPV) with Pap smear every 5 years or a regular cytology alone (without HPV testing) every 3 years. Women with an average risk shouldn't be screened more than once every 3 years.
Chlamydia Infection Screening	Plan pays 100%	No Benefit	For younger women and women at high risk.
Contraception	Plan pays 100%	No Benefit	Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs or IUDs. Counseling and follow-up care are included with this benefit Birth control pills will be covered under your Rx benefits.
Depression Screening	Plan pays 100%	No Benefit	Screening for depression in the general adult population, including pregnant and postpartum women.
Domestic and Interpersonal Violece Screening	Plan pays 100%	No Benefit	Annual screening for women to obtain a referral to initial intervention services, which includes counseling, education, harm reduction strategies and referral to appropriate support services.
Folic Acid Supplements	Plan pays 100%	No Benefit	All women who are planning or capable of pregnancy take a daily supplement containing 0.4 - 0.8 mg.

Gestational Diabetes Screening	Plan pays 100%	No Benefit	For women 24 to 28 weeks pregnant and / or at high risk of developing gestational diabetes should be screened prior to 24 weeks of gestation.
Gonorrhea Screening	Plan pays 100%	No Benefit	For all women at higher risk.
Hepatitis B Screening	Plan pays 100%	No Benefit	For pregnant women at their first prenatal visit.
Human Immunodeficiency Virus (HIV) Screening and Counseling	Plan pays 100%	No Benefit	For women sexually active.
Human Papillomavirus (HPV) DNA Test	Plan pays 100%	No Benefit	One test every 3 years for women with normal cytology results who are 30 or older.
Osteoporosis Screening	Plan pays 100%	No Benefit	For women over age 60 or at high risk.
Preeclampsia	Plan pays 100%	No Benefit	Screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy.
Rh Incompatibility Screening	Plan pays 100%	No Benefit	For pregnant women and follow-up testing for women at higher risk.
Sexually Transmitted Infection (STI) and Sexually transmitted Diseases (STD) Screening and Counseling, includes Gonorrhea & Syphilis Screening	Plan pays 100%	No Benefit	Counseling for sexually active women.
Syphilis Screening	Plan pays 100%	No Benefit	For all pregnant women or other women at increased risk.
Tobacco Use Screening and Interventions	Plan pays 100%	No Benefit	
Urinary Tract or other Infection Screening for Pregnant Women	Plan pays 100%	No Benefit	
Covered Preventive Services for Children			
Wellness Office Visits and Lab Services	**Network Providers**	**Out-of-Network Providers**	**Benefit Limits**
Office Visit Exam & Includes Services For:	Plan pays 100%	No Benefit	Limited to preventive diagnosis only.
Alcohol and Drug Use Assessments	Plan pays 100%	No Benefit	
Autism Screening	Plan pays 100%	No Benefit	For children at 18 months to 24 months.
Behavioral Assessments	Plan pays 100%	No Benefit	For children to age 18.
Blood Pressure Screening	Plan pays 100%	No Benefit	For children to age 18.
Cervical Dysplasia Screening	Plan pays 100%	No Benefit	For sexually active females.
Congenital Hypothyroidism Screening	Plan pays 100%	No Benefit	For newborns.
Contraception	Plan pays 100%	No Benefit	Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs or IUDs. Counseling and follow-up care are included with this benefit Birth control pills will be covered under your Rx benefits.
Depression Screening	Plan pays 100%	No Benefit	Screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years.
Developmental Screening	Plan pays 100%	No Benefit	For children under age 3 and surveillance throughout childhood.
Dyslipidemia Screening	Plan pays 100%	No Benefit	For children at high risk of lipid disorders.
Fluoride Chemoprevention Supplements	Plan pays 100%	No Benefit	For children without fluoride in their water sources.
Gonorrhea Preventive Medication for the Eyes of all Newborns	Plan pays 100%	No Benefit	
Hearing Screenings	Plan pays 100%	No Benefit	For all newborns.
Height, Weight, and Body Mass Index Measurements	Plan pays 100%	No Benefit	For children to age 18.
Hemalocrit or Hemoglobin Screening	Plan pays 100%	No Benefit	For children to age 18.
Hemoglobinopathies of Sickle Cell Screening	Plan pays 100%	No Benefit	For all newborns.
HIV Screening	Plan pays 100%	No Benefit	For sexually active children.
Hypothyroidism Screening for Newborns	Plan pays 100%	No Benefit	

Immunizations: *Acellular Perfussis *Diphtheria, Tetanus, Pertussis *Haemophilus influenza type B *Hemophilia *Hepatitis A *Hepatitis B *Human Papillomavirus *Inactivated Poliovirus *Influenza (Flu Shot) * Measles, Mumps, Rubella *Meningococcal *Meningococcal B Vaccine *Pneumococcal *Rotavirus *Varicella	Plan pays 100%	No Benefit	For children to age 18.
Interpersonal and Domestic Violence Screening	Plan pays 100%	No Benefit	Annual screening for women to obtain a referral to initial intervention services, which includes counseling, education, harm reduction strategies and referral to appropriate support services
Iron Supplements	Plan pays 100%	No Benefit	For children ages 6 to 12 months at risk of anemia.
Lead Screening	Plan pays 100%	No Benefit	For children at risk of exposure.
Medical History	Plan pays 100%	No Benefit	For all children throughout development.
Obesity	Plan pays 100%	No Benefit	Screening for obesity in children and adolescents six years and older and offer to refer them to comprehensive, intensive behavioral interventions to promote improvements in weight status.
Oral Health	Plan pays 100%	No Benefit	At risk assessment for children ages newborn to age 10.
Phenylketonuria (PKU) Screening	Plan pays 100%	No Benefit	For genetic disorders in newborns.
Sexually Transmitted Infection (STI) and Sexually Transmitted Diseases (STD) Screening and Counseling	Plan pays 100%	No Benefit	For children at higher risk, includes gonorrhea preventive medication for newborn eyes.
Syphilis Sceening	Plan pays 100%	No Benefit	For all adolescents at higher risk
Tuberculin Testing	Plan pays 100%	No Benefit	For children at higher risk of tuberculosis to age 18.
Vision Screening	Plan pays 100%	No Benefit	Screening at least once in all children ages 3 to 5 years to detect amblyopia or risk factors.

Prescription Coverage		
Prescription Benefits	**Preventative Prescription Drugs:** $0 Copay (Limited to Generic Preventive Only)	
	Preferred Prescription Drugs (Vault Rx): Tier 1: Under $10 Tier 2: Under $25 Tier 3: Under $50 Tier 4: Over $50	
	Additional Covered Drugs (Vault Rx Plus): Formulary Generic: $10 Formulary Brand: $30	**Subject to combined separate prescription drug deductible of:** Individual: $1,000 Family: $2,000 **Subject to combined separate prescription drug maximum monthly benefit.** Individual Monthly Maximum: $1,000 Family Monthly Maximum: $2,000

We believe this coverage is a Non-Grandfathered health plan under the Patient Protection and Affordable Care Act. (PPACA)
All claims are subject to plan provisions at the time of service. Any benefits quoted telephonically or in writing is not a guarantee of payment. Claims are determined upon receipt of the claim and any additional information required to make a benefit determination.

01012025

Plan Limitations and Exclusions

Plan Exclusions

1. Abortion. Services, supplies, care, or treatment in connection with an abortion.

2. Acupuncture or Acupressure.

3. Adoption. Any charges associated with Adoption.

4. Ambulance Charges.

5. Bereavement Counseling Services and Supplies.

6. Blood or Blood Derivatives.

7. Chemotherapy.

8. Chiropractic Services/Spinal Adjustments.

9. Complications of Non-Covered Treatments. Care, services, or treatment required as a result of complications from a treatment not covered under the Plan.

10. Cosmetic Procedures. A procedure performed primarily for psychological purposes or to preserve or improve appearance rather than to restore the anatomy and /or functions of the body which are lost or impaired due to an illness or injury.

11. Counseling Services. Counseling for educational, social, occupational, religious, or other maladjustments. Counseling for treatment of a gambling addiction. Sensitivity or stress management training, self-help training unless specifically stated in the Schedule of Benefits. Counseling services mandated by the PPACA are covered as specifically stated in the Schedule of Benefits.

12. Custodial Care. Services or supplies provided mainly as a rest cure, maintenance, or Custodial Care.

13. Day Treatment. Means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting. The treatment program generally consists of a minimum of 20 hours of scheduled programming extended over a minimum of five days per week. The program is designed to treat patients with serious mental or nervous disorders and offers alternative to Inpatient treatment.

14. Dental Care. Services are excluded except those that are accidental and treated as a covered service listed on the Schedule of Benefits.

15. Dialysis.

16. Educational or Vocational Testing. Services for educational or vocational testing or training, except in regard to education and training for diabetic management.

17. Error. This Plan reserves the right to recover any payments made by this Plan that were:

- **a.** Made in error, or

b. Made to you or any party on your behalf where this Plan determines the payment to you or any party is greater than the amount payable under this Plan, or

c. This Plan has the right to recover against you if this Plan has paid you or any other party on your behalf.

18. Exams or Treatment Required by Third Party. Physical, psychiatric, and psychological exams or treatments and related services that are required by third parties. For example, exams and tests that are required for recreational activities, employment, insurance, and school; court-ordered exams and services, except when they are medically necessary services.

19. Excess Charges. The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Maximum Allowable Charge.

20. Exercise Programs. Exercise programs for treatment of any condition.

21. Experimental. Care and treatment that is either Experimental or Investigational.

22. Eye Care. Radial keratotomy, Lasik surgery, or other eye surgery to correct refractive disorders. Lenses for the eyes and exams for their fitting.

23. Foot Care. Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions, and treatment of corns, calluses, toenails, and foot inserts.

24. Foreign Travel. Non-emergent care, treatment, or medical supplies obtained outside of the U.S.

25. Government Coverage. Care, treatment, or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.

26. Hair Loss. Care and treatment for hair loss including hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician.

27. Hearing Aids, Including Cochlear Implants and Hearing Examinations. Charges for services including exams and supplies in connection with hearing aids or cochlear implants.

28. Hospice Care Services and Supplies or Bereavement Counseling.

29. Illegal Acts. Charges for services received for Injury or Sickness occurring directly or indirectly as a result of active participation in an Illegal Act, or active participation in a riot or public disturbance.

a. It is not necessary that criminal charges be filed, or if filed, that a conviction result, or that a sentence of imprisonment be imposed for this exclusion to apply.

b. Proof beyond a reasonable doubt is not required.

c. This exclusion does not apply if the Injury or Sickness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

d. Services received as a result of illness or injury caused or contributed to by the Covered Person committing or attempting to commit any of the following or engaging in conduct which would amount to any of the following if a charge had been made, regardless of whether a charge was filed or guilt was determined:

i. A felony;

ii. Any illegal occupation;

iii. A misdemeanor or other offense involving theft, fighting, disorderly conduct, or other breach of the peace; or

iv. A misdemeanor or other offense involving the use of alcohol or drugs, including, but not limited to any crime or offense involving driving or being in actual physical control of a motor vehicle or any other means of conveyance propelled in part or in whole by an engine or motor, for example, a boat or ATV, while under the influence of alcohol or drugs.

30. Illegal Drugs or Medications. Services, supplies, care, or treatment to a Covered Person for Injury or Sickness resulting from that Covered Person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen, or narcotic not administered on the advice of a Physician.

a. Expenses will be covered for Injured Covered Persons other than the person using controlled substances.

b. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

31. Impotence. Care, treatment, services, or supplies in connection with treatment for impotence. Some plans may cover medications under the prescription drug benefit.

32. Infertility. Care, supplies, services, and treatment for infertility, artificial insemination, or in vitro fertilization, unless listed as covered in the Schedule of Medical Benefits.

33. Long Term Care.

34. Marital, Pre-Marital, or Family Counseling. These services are not a covered benefit.

35. No Charge. Care and treatment for which there would not have been a charge if no coverage had been in force.

36. No Obligation to Pay. Charges incurred for which the policy has no legal obligation to pay.

37. No Physician Recommendation.

a. Care, treatment, services, or supplies not recommended and approved by a Physician; or

b. Treatment, services, or supplies when the Covered Person is not under the regular care of a Physician.

c. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

38. Not Specified as Covered. Non-traditional medical services, treatments, and supplies which are not specified as covered under this policy.

39. Obesity. Care and treatment of obesity, weight loss, or dietary control whether or not it is a part of the treatment plan for another Sickness.

a. Specifically excluded are charges for Bariatric Surgery, including but not limited to:

i. Gastric Bypass,

ii. Stapling and Intestinal Bypass, and

iii. Lap Band Surgery, including reversals.

iv. Medically Necessary charges for Morbid Obesity will not be covered.

v. Nutritional counseling will be covered under preventive care.

40. **Occupational.** Care and treatment of an Injury or Sickness that is occupational. Occupational means that it arises from work for wage or profit, including self-employment.

41. **Out of Country Services.**

42. **Outpatient Hospital Services.** This includes Surgical and other ancillary services performed in an outpatient hospital setting.

43. **Oxygen.**

44. **Plan Design Excludes.** Charges excluded by the policy design as mentioned in this document.

45. **Private Duty Nursing Care.**

46. **Prosthetic Devices.** Purchase, fitting and repair of fitted prosthetic devices which replace body parts.

47. **Reconstructive Surgery.** Correction of abnormal congenital conditions and reconstructive mammoplasties.

48. **Replacement Braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs.

49. **Residential Treatment Facilities.** Inpatient and outpatient services associated with Mental Health, Chemical Dependency and Substance Abuse.

50. **Respiration Therapy.**

51. **Sales Tax.**

52. **Services Before or After Coverage.** Care, treatment, or supplies for which a charge was incurred before a person was covered under this policy or after coverage ceased under this policy.

53. **Sex Changes.** Care, services, or treatment for non-congenital transsexualism, gender dysphoria, or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical, or psychiatric treatment.

54. **Sexual Dysfunction.** Behavioral treatment or drug therapy for sexual dysfunction and sexual function regardless if cause of dysfunction is due to physical or psychological reasons.

55. **Skilled Nursing Facility** or Physician Care.

56. **Sleep Disorders or Studies.**

57. **Smoking / Tobacco Cessation.** Care and treatment for smoking cessation programs, including smoking deterrent patches. Counseling for tobacco use is covered under preventive care.

58. **Speech Therapy.**

59. **Sterilization Services For Men.**

60. **Surgical Services.** Any surgery performed in a primary care office, specialist office, or outpatient hospital setting is specifically excluded.

61. Surgical Sterilization Reversal. Care and treatment for reversal of surgical sterilization.

62. Surrogate Pregnancy Services. Services incurred in connection with an agreement to act as a surrogate mother. This excludes pregnancy-related charges incurred by an insured who is acting as a surrogate mother as well as pregnancy-related charges incurred by a non-insured who is acting as a surrogate for an insured.

63. TMJ or Orthognathic Services. Treatment is not covered.

64. Transplant Services.

65. Travel or Accommodations. Charges for travel or accommodations, whether or not recommended by a Physician.

66. Vision Therapy Services. Services incurred to treat vision therapy is not covered.

67. War. Any loss that is due to a declared or undeclared act of war. Including nuclear reaction or the release of nuclear energy. This exclusion will not apply if the loss is sustained within 90 days of the initial incident. To be covered under the policy, the loss must be caused by fire, heat, explosion or other physical trauma that is a result of the release of nuclear energy. The covered person must be within a 25-mile radius of the release site at the time of the release or within 24 hours of the start of there lease.

68. Workers Compensation. Injury or illness that is covered by any Workers Compensation or Occupational Disease law.