Health Insurance Exclusions and Limitations

Date: [Insert Date]

[Your Name]

[Your Address]

[City, State, Zip Code]

[Recipient Name]

[Recipient Address]

[City, State, Zip Code]

Dear [Recipient Name],

We are writing to inform you about the exclusions and limitations that apply to your health insurance policy with [Insurance Company Name]. It is essential that you understand these aspects to make informed decisions regarding your healthcare.

Exclusions

- Pre-existing conditions not covered within the first [x] months of the policy.
- Cosmetic procedures and treatments.
- Experimental or investigational treatments.
- Services that are not medically necessary.

Limitations

- Annual maximum benefit of $[amount].
- Lifetime maximum benefit of $[amount].
- Coverage for specific services limited to [xx] visits per year.
- Network restrictions apply; out-of-network services may incur higher costs.

Please review your policy documents for additional details on coverage, exclusions, and limitations. If you have any questions, feel free to contact our customer service at [contact number] or [email address].

Thank you for choosing [Insurance Company Name].

Sincerely,

[Your Name]

[Your Position]

[Insurance Company Name]

[Company Contact Information]