

The following is a list of services, supplies, equipment and benefits that are limited in or excluded from Coverage.

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### A

**Abortion** - Elective termination of pregnancy is covered during the first 12 weeks of pregnancy. The Plan covers abortion after the first 12 weeks only if the life of the mother would be endangered if the fetus were carried to full term; or if there is reasonable medical evidence of lethal fetal abnormalities; or in the case of rape or incest.

**Acupuncture** - is excluded from Coverage.

**Adaptations to the Home** - are excluded from Coverage. Examples include, but are not limited to, handrails, ramps, escalators, elevators, or other disability modifications.

**Allergy Testing** - Food allergy ingestion testing, IGE immunoassays for quantitative In-vitro allergy testing for diagnosis of allergic rhinitis, including but not limited to, RAST is excluded from Coverage.

**AMA - Against Medical Advice** - A Member may opt not to comply with recommended treatment. In such cases, the Plan will not assume any further liability for the particular condition unless the Member later decides to follow prescribed treatment under the care of the ordering physician and subject to the terms of the Member's Coverage.

**Ambulance Services** – other than for emergency transportation are excluded from Coverage unless authorized by the Plan.

**Ancillary Services** - non-medical ancillary services for which the Member is referred are excluded from Coverage. These include, but are not limited to, vocational rehab services, employment counseling, marriage counseling, expressive therapies and health education.

**Anesthesia** – General anesthesia in a Physician's office is excluded from Coverage.

**Aromatherapy** - is excluded from Coverage.

**Autopsies** - are excluded from Coverage.

### B

**Batteries** - Batteries for repair or replacement is excluded from Coverage. This does not apply to batteries for motorized wheelchairs.

**Behavioral Health**– Optima Behavioral Health Services, Inc. administers mental health and substance abuse services for the Plan. The following services are excluded from Coverage:

- Medically Necessary Treatments - Any services, supplies or treatments not specifically listed as Covered as well as services and any other procedures determined not to be Medically Necessary are excluded from Coverage.
- The Plan only covers psychiatric confinement in a Plan Hospital.

- All services, other than emergency services that have not been authorized by Optima Behavioral Health Services, Inc. are excluded from Coverage.
- Non-medical ancillary services are not covered including but not limited to vocational rehabilitation services, employment counseling, expressive therapies, and health education are excluded from Coverage.
- Psychological examinations, testing or treatment for the purpose of obtaining or maintaining employment or insurance, or related to judicial or administrative proceedings are excluded from Coverage.
- Court ordered examinations or care unless medically necessary is excluded from Coverage.
- Services delivered while detained under a Temporary Detention Order (TDO) are excluded from coverage.
- Psychiatric treatment for sexual dysfunction or sexual therapy, mental retardation or learning disabilities is excluded from Coverage.
- Psychoanalysis to complete degree or residency requirements is excluded from Coverage.
- Pastoral counseling or relationship counseling is excluded from Coverage.
- Psychological testing for educational purposes is excluded from Coverage.
- Residential level of care or treatment is excluded from Coverage.
- Other non-covered services listed in this manual that could be deemed mental health services are excluded from Coverage.
- Sex Change Operations and any medical treatment of gender identity disorders are excluded from Coverage.
- Services not listed as covered even if a provider or clinician is licensed to provide such services.
- Services provided by behavioral health clinicians not licensed for independent practice in the Commonwealth of Virginia are excluded from Coverage. Services include, but are not limited to medication dispensing in methadone

**Biofeedback** - is excluded from Coverage except when authorized by the Plan.

**Blood Pressure Monitors** - are excluded from Coverage unless authorized by the Plan.

**Blood and Blood Products** - are excluded from Coverage. The costs of securing the services of blood donors are excluded from Coverage. The cost of transportation and storage of blood if used in or outside the Plan's Service Area is excluded from Coverage.

**Bone Densitometry** - studies done more frequently than once every two years are excluded from Coverage unless authorized by the Plan.

**Bone or Joint treatment** – The Plan does not exclude coverage for diagnostic and surgical treatment involving any bone or joint of the head, neck, face or jaw or impose limits that are more restrictive than limits on coverage applicable to such treatment involving any bone or joint of the skeletal structure if the treatment is required because of a medical condition or injury which prevents normal function of the joint or bone and is deemed medically necessary to attain functional capacity of the affected part.

**Botox injections** - are excluded from Coverage unless approved by the Plan. Botox injections for the following are excluded from Coverage: headaches, cosmetic procedures, bone and joint conditions, and writer's cramp.

**Breast Augmentation/Mastopexy** - Procedures requested for the purpose of correction of cosmetic physical imperfections, except as required by State or Federal law regarding breast reconstruction and symmetry following mastectomy are excluded from Coverage.

**Breast Ductal Lavage** - is excluded from Coverage.

**Breast Milk** – donor breast milk is excluded from Coverage.

## C

**Chelation Therapy** - is excluded from Coverage for other than arsenic, copper, iron, gold, mercury or lead poisoning.

**Chiropractic Care** - which shall mean the detection, treatment and correction of structural imbalance, subluxation or misalignment of the vertebral column in the human body, for the purpose of alleviating pressure on the spinal nerves and its associated effects related to such structural imbalance, misalignment or distortion, by physical or mechanical means is excluded from Coverage unless covered under a Rider.

**Circumcision** - is excluded from Coverage for non-medically indicated reasons after six weeks of age.

**Cold Therapy Machine** - is excluded from Coverage.

**Contact Lenses** - or eyeglasses or the fitting thereof are excluded from Coverage, except for the first pair of lenses (this may include contact lens, or placement of intraocular lens or eyeglass lens only) following cataract surgery.

**Cosmetic Surgery** - Emotional conflict or distress does not constitute medical necessity. The following are excluded from Coverage:

- Any cosmetic surgery and any hospital, physician, or other health service related thereto, except to the extent Medically Necessary to restore function;
- Non-Medically Necessary treatment or services resulting from complications due to cosmetic and/or experimental procedures;
- Breast Augmentation/ Mastopexy procedures requested for the purpose of correction of cosmetic physical imperfections, except as required by State or Federal law regarding breast reconstruction and symmetry following mastectomy;
- Tattoo removal;
- Keloid treatment as a result of the piercing of any body part;
- Consultations and/or office visits for the purpose of obtaining cosmetic and/or experimental procedures;
- Penile Implants;
- Vitiligo treatments by laser, light or other methods are excluded from Coverage.

**Covered Services by Another Payor** - the cost of services, which are or may be covered through a group insurance mechanism or governmental program, such as Workers Compensation, occupational disease laws and other employers' liability laws, are excluded from Coverage. Should a Member have the cost of services denied by one of the above insurance programs, the Plan will only consider payment of covered services in those cases where the Member received services in accordance with the Plan's referral procedures. The Plan will not cover the cost of services that were denied by the above insurance programs for failure to meet administrative or filing requirements.

**Custodial Care** - or domiciliary care, rest cures, or any examination and/or care ordered by a court of law, which has not received prior authorization by the Plan and has been arranged through, or provided at, a Plan Provider is excluded from Coverage.

## D

**Dentistry/Oral Surgery** - the following is a listing of specific dental and oral surgery exclusions, including, but not limited to:

1. **Dentistry**
  - Restorative services and supplies necessary to treat, repair or replace sound natural teeth are excluded from Coverage. Medically necessary dental services as a result of accidental injury,

regardless of the date of such injury, are Covered Services under the Plan. For injuries occurring on or after the effective date of coverage treatment must be sought within 60 days of the accident.

- Medically Necessary dental services performed during an emergency room visit immediately after a traumatic injury and in conjunction with the initial stabilization of the traumatic injury are covered subject to utilization review for Medical Necessity.
- Services to restore appearance or for cosmetic purposes are excluded from Coverage.
- Dental implants and any preparation work for implants or dentures are excluded from Coverage.
- Dental services performed in a hospital or any outpatient facility except as described in the Member's Covered Services under "Hospitalization and Anesthesia for Dental procedures" are excluded from Coverage.

## 2. Oral Surgery

- Oral surgery, which is part of an orthodontic treatment program, is excluded from Coverage.
- Orthodontic treatment prior to Orthognathic surgery is excluded from Coverage.
- Dental implants and any preparation work for implants or dentures are excluded from Coverage.
- Extraction of wisdom teeth is excluded from Coverage unless covered under a rider

## 3. Dental Care

- Dental care, treatment, supplies, orthodontia, extractions, repositioning, X-rays, periodontal work, or any other services dental in nature are excluded from Coverage.
- Dental implants and any preparation work for implants or dentures are excluded from Coverage.

**Disposable Medical Supplies** - are excluded from Coverage. This includes, but is not limited to, medical dressings, disposable diapers, any over the counter supplies, such as bandages, tape, gauze pads, alcohol, iodine, peroxide.

**Driver Training** - is excluded from Coverage.

**Durable Medical Equipment (DME)** - The rental, purchase, repair and replacement of durable medical equipment are limited to the level of Coverage indicated on the Face Sheet or Schedule of Benefits. DME and surgical equipment benefits are excluded for:

- More than one item of equipment for the same or similar purpose.
- An amount that exceeds the cost of a similar supply that would have been sufficient to safely and adequately treat the Member's physical condition.
- Equipment and appliances which are not uniquely relevant to the treatment of disease.
- Disposable medical supplies and medical equipment are excluded from Coverage. This includes, but is not limited to, medical dressings, disposable diapers, any over the counter supplies, such as bandages, tape, gauze pads, alcohol, iodine, peroxide.
- DME for use in altering air quality or temperature or for exercise or training.
- DME primarily for the comfort and well being of the Member.
- Batteries for repair or replacement. This does not apply to batteries for motorized wheelchairs.
- Blood Pressure Monitors unless authorized by the Plan.]

## E

**Electron Beam Computer Tomography (EBCT)** - is excluded from coverage.

**Educational/Teacher Services/Evaluations** - educational, tutorial, evaluation, testing, screening and any other services relating to school or classroom performance is excluded from Coverage. This exclusion does not apply to those services that qualify as, and are covered under the Plan's benefit for Early Intervention Services.

**Enteral or Parenteral Feeding** - Supplements and/or supplies is excluded from Coverage unless they are used as the sole source of nutrition. Over the counter supplements are excluded from Coverage.

**Exercise Equipment** - is excluded from Coverage, including, but not limited to bicycles, treadmills, stair climbers, pool or health club memberships.

**Experimental Treatment and Procedures** - are excluded from Coverage. Any drug, device, medical treatment or procedure may be considered experimental or investigative if:

- The majority of the medical community does not support the use of this drug, device, medical treatment or procedure; or
- The use of this drug, device, medical treatment or procedure may have been shown to be unsafe and/or of no or questionable value as reported by current scientific literature and/or regulatory agencies; or
- The research regarding this drug, device, medical treatment or procedure may be so limited that an evaluation of safety and efficacy cannot be made; or
- The drug or device is not approved for marketing by the Food and Drug Administration (FDA); or
- The drug, device, medical treatment or procedure is currently under study in a Phase I, Phase II clinical trial, an experimental study/investigational arm of a Phase III clinical study, or otherwise under study to determine safety and efficacy or to compare its safety and efficacy to current standards of care; or
- The drug device or medical services is classified by the FDA as a Category B Non-experimental/investigational drug, device, or medical treatment.

**Eye Examination** - or any corrective or protective eyewear required by an employer as a condition of employment is excluded from Coverage.

**Eye Glasses** - or contact lenses or the fitting thereof are excluded from Coverage, except for the first pair of lenses (including contact lens, or placement of intraocular lens or eyeglass lens only.) following cataract surgery.

**Eye Movement Desensitization and Reprocessing Therapy** - is excluded from Coverage.

**Eye Corrective Surgery** - is excluded from Coverage, including, but not limited to, Radial Keratotomy, PRK and LASIK.

## **F**

**Food Allergy Testing** - is excluded from Coverage.

**Foot Care** –

- The following foot care services are excluded from Coverage unless authorized by the Plan:
  - operations which involves the exposure of bones, tendons, or ligaments for the treatment of tarsalgia, metatarsalgia or bunions.
  - Treatment and services related to plantar warts
- The following are excluded from Coverage except for those Members with Diabetes or severe vascular problems:
  - Foot care including, but not limited to, the removal of corns or calluses and the trimming of nails,
  - Treatment and services related to flat-feet, fallen arches, or chronic foot strain;
  - Foot Orthotics of any kind, including but not limited to, customized or non-customized shoes, boots, and inserts.

## **G**

### **Genetic Testing and Counseling –**

- Genetic testing and counseling are excluded from Coverage except for amniocentesis, HLAB 27, and infant chromosomal analysis.
- BRAC1 and BRAC2, and FAP or AFAP are covered for colorectal cancer or other testing when Pre-Authorized by the Plan.

**GIFT programs (Gamete Intrafallopian Transfer)** - are excluded from Coverage.

**Growth Hormones** – are covered only under the Plan’s Outpatient Prescription Drug Rider.

## **H**

**Hearing Aids** - are excluded from Coverage, including but not limited to, fittings, molds and/or supplies, such as batteries, unless covered under a Rider.

**Heart** - Artificial and/or mechanical heart devices, placement and other related expenses are excluded from Coverage.

**Home Births** – are excluded from Coverage.

**Home Health** - Home Health Care Skilled Services are limited or excluded as follows:

- Services or supplies which are not specified in Home Health Care Plans are excluded from Coverage;
- Services for any Member who is not home-bound as determined by the Plan are excluded from Coverage;
- Custodial Care is excluded from Coverage;
- Transportation services are excluded from Coverage.

**Hypnotherapy** - is excluded from Coverage.

## **I**

**IGE** - IGE immunoassays for quantitative In-vitro allergy testing for diagnosis of allergic rhinitis, including but not limited to, RAST is excluded from Coverage.

**Immunizations** - as related to foreign travel and/or employment are excluded from Coverage.

**Implants** - Breast implants, except after mastectomy to produce symmetry, and are excluded from Coverage.

**Incarceration** - Services and treatments required or performed while the Member is incarcerated in a Local, State, Federal or Community Correctional Facility are excluded from Coverage.

**Infertility** - All services, tests, medications, and treatments in connection with the diagnosis or treatment of Infertility, and all services, tests, medications, and treatments that aid in or diagnose potential problems with conception are excluded from Coverage unless covered under a Rider, including, but not limited to:

- In-Vitro Fertilization programs, Artificial insemination or any other types of artificial or surgical means of conception including any drugs administered in connection with these procedures;
- GIFT/ZIFT programs;
- Reproductive material storage;
- Treatment related to sexual organ function, dysfunction or inadequacies, including but not limited to, impotency;

- Semen recovery or storage, or sperm washing;
- Infertility Services needed due to a reversal of sterilization;
- Services to reverse voluntary sterilization;
- Semen analysis;
- Sims-Huhner test (smear);
- Drugs used to treat infertility.

## **J**

## **K**

**Keloids** – the treatment of keloids as a result of body piercing or pierced ears is excluded from Coverage.

## **L**

**Laboratory Services** – For Optima Vantage Plans Laboratory services received from Non-Plan Providers or laboratories are excluded from Coverage. For Optima POS plans laboratory services received from Non-Plan Providers are covered under out of network benefits only.

**Laser Therapy** - for Vitiligo or psoriasis is excluded from Coverage.

**Lung Cancer Screening Helical CT Scans** - are excluded from Coverage.

## **M**

**Magnetic Resonance Spectroscopy** - is excluded from Coverage.

**Massage Therapy** - is excluded from Coverage.

**Maternity Services** - Home births are excluded from Coverage.

**Maximum Benefit** - Amounts in excess of a benefit limit as stated in the Face Sheet or Schedule of Benefits are excluded from Coverage.

**Medically Necessary Treatments** - Any services, supplies, treatments or procedures not specifically listed as a Covered Service, and any other services, supplies, or treatments or procedures determined not to be Medically Necessary are excluded from Coverage.

### **Medical Equipment and Supplies –**

- Any disposable or convenience medical equipment, appliances, devices, and/or supplies are excluded from Coverage, including but not limited to: exercise equipment, air conditioners, purifiers, humidifiers and dehumidifiers, whirlpool baths, hypoallergenic pillows or bed linens, telephones, handrails, ramps, elevators and stair glides, orthotics, changes made to vehicles, residences or places of business, adaptive feeding devices, adaptive bed devices, water filters or purification devices and other similar equipment and supplies.
- Disposable Medical Supplies are excluded from Coverage, including, but not limited to, medical dressings, disposable diapers, any over the counter supplies, such as bandages, tape, gauze pads, alcohol, iodine, peroxide.

**Membership Fees** - to health and/or athletic clubs are excluded from Coverage.

**Mobile Cardiac Outpatient Telemetry** - (MCOT) is excluded from coverage.

**Morbid Obesity** - Coverage for the treatment of morbid obesity through gastric bypass surgery or other such methods, surgeries, services or drugs are excluded from Coverage unless covered under a Rider.

**Motorized or Power Operated Vehicles** - are excluded from Coverage, including, but not limited to, any adaptations to motorized or power operated vehicles and/or chair lifts.

## N

**Neuro-cognitive therapy** - Following a neurological event or to restore cognitive deficits neuro-cognitive therapy is excluded from Coverage.

**Neuropsychological Services** - including, but not limited to, psychological examinations, testing or treatment for the purpose of obtaining or maintaining employment or insurance, or related to judicial or administrative proceedings are excluded from Coverage unless approved by the Plan.

**Newborn Coverage** - for the newborn or other child of a Dependent child is excluded from Coverage.

## O

**Obstetrical Care** - Home births are excluded from Coverage.

### Oral Surgery

- Dental implants, and any preparation work for implants or dentures are excluded from Coverage
- Extraction of wisdom teeth is excluded from Coverage unless covered under a rider.
- Oral surgery, which is part of an orthodontic treatment program, is excluded from Coverage.
- Orthodontic treatment prior to Orthognathic surgery is excluded from Coverage.

**Orthoptics** - or vision/visual training and any associated supplemental testing are excluded from Coverage.

**Out Of Network Medical and Laboratory Services** – For Optima Vantage Plans any services other than Emergency Services received from Non-Plan Providers, whether referred or directed by a Plan Provider, are excluded from Coverage unless Pre-authorized by the Plan. For Optima POS Plans any services other than Emergency Services received from Non-Plan Providers, whether referred or directed by a Plan Provider, are covered under out of network benefits only

## P

**Pass Devices (Patient Activated Serial Stretch)** – are excluded from Coverage.

**Paternity Testing** – paternity testing is excluded from Coverage.

**Penile implants** - are excluded from Coverage.

**Personal comfort items** - are excluded from Coverage, which include, but are not limited to, telephones, televisions, extra meal trays and personal hygiene items including, but not limited to, under pads, diapers, ice bags, chairs, air conditioners, water purifiers, humidifiers, dehumidifiers, saunas, swimming pools or hot tubs.

**PET Scans** - Positron Emission Tomography (PET) Scans are excluded from Coverage unless authorized by the Plan.

### Physician Examinations -

- Physicals for employment, insurance or recreational activities are excluded from Coverage.
- Executive physicals are excluded from Coverage.
- School physicals are excluded from Coverage, except when a Member has not had a health assessment with his or her physician during the calendar year.

- For Optima Vantage Plans a second opinion from a Non-Plan Provider is covered only when authorized by the Plan.
- Services or supplies not prescribed, performed, or directed by a provider licensed to do so.

**Physician's clerical charges** - are excluded from Coverage. This includes, but is not limited to; charges for no show appointments, telephone calls, and completion of forms, transfer of medical records, the cost of copying medical records or the generation of correspondence to other parties.

**Prescription Drugs** - outpatient prescription drugs are excluded from Coverage unless covered under a Rider.

**Prescription Drug Rider Exclusions** - Any drugs not specifically listed as covered in the Prescription Drug Rider are excluded from Coverage. All other drugs and over-the-counter medications, even if written on a prescription blank, are excluded from Coverage unless they are listed on the Plan's list of covered Preferred and Standard drugs. For a full listing of excluded outpatient prescription drugs, please reference your Plan's Prescription Drug Rider exclusions.]

**Private Duty Nursing** - is excluded from Coverage.

## Q

## R

**RAST Testing** -IGE immunoassays for quantitative In-vitro allergy testing for diagnosis of allergic rhinitis, including but not limited to, RAST are excluded from Coverage.

**Reconstructive surgery** - is excluded from Coverage unless such services follow trauma which causes anatomic functional impairment or is needed to correct a congenital disease or anomaly which has resulted in a functional defect. If the trauma occurred before the Member's effective date of Coverage, the reconstructive surgery is covered subject to the Plan's pre-existing condition exclusion provisions and Medical Necessity determination. Emotional conflict or distress does not constitute Medical Necessity. Breast reconstruction following mastectomy is covered.

**Remedial Education and/or Programs** - are excluded from Coverage, including services which are extended beyond the period necessary for the evaluation and diagnosis of learning and behavioral disabilities or for mental retardation or for autism disabilities.

**Routine Disposable Medical Supplies** - are excluded from Coverage. This includes, but is not limited to, medical dressings, disposable diapers, any over the counter supplies, such as bandages, tape, gauze pads, alcohol, iodine, peroxide.

## S

**Saliva Tests** - are excluded from Coverage.

**Second Opinions** – For Optima Vantage Plans a second opinion from a Non-Plan Provider is covered only when authorized by the Plan.

**Services** – the following services are excluded from Coverage:

- Services for which a charge is not normally made;
- Services or supplies not prescribed, performed or directed by a provider licensed to do so;
- Services if they are for dates of service before the Member's effective date under the Plan or after the Member's Coverage under the Plan ends;

- Telephone consultations, charges for missed appointments, charges for completing forms or charges associated with copying medical records.
- Services not specifically listed or described as covered under this Plan.
- Non-medically necessary complications of non-covered services including medical, mental health and surgical services related to the complication.
- For Optima Vantage plans treatment and services, other than Emergency Services, received outside of the United States of America are excluded from Coverage.
- For POS Plans treatment and services, other than Emergency Services, received outside of the United States of America are covered under out of network benefits only.
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**Sex Change Operations** - and any treatment of gender identity disorders are excluded from Coverage.

**Smoking Cessation** - including the drugs and treatment associated with smoking cessation are excluded from Coverage.

**Spinal Manipulation** - is excluded from Coverage, unless covered under a Chiropractic Care Rider.

**Sterilization** - Reversal of voluntary sterilization and infertility services required because of such reversal are excluded from Coverage.

**Supplies** - Disposable medical supplies are excluded from Coverage. This includes, but is not limited to, medical dressings, disposable diaper, any over the counter supplies, such as bandages, tape, gauze pads, alcohol, iodine, peroxide.

## T

**Therapies** - Physical, speech and occupational therapies will be limited in Coverage and only covered to the extent of restoration to the pre-trauma or pre-illness level.

- Therapies will be covered only to the extent of restoration to the level of the pre-trauma, pre-illness or pre-condition status;
- Therapies for developmental delay or abnormal speech pathology are excluded from Coverage except as covered through Early Intervention Services;
- Therapies which are primarily educational in nature, including but not limited to, special education or lessons in sign language are excluded from Coverage;
- Therapies performed to correct an impairment resulting from a functional nervous disorder (i.e. stuttering, stammering) are excluded from Coverage;
- Therapies to maintain current status or level of care are excluded from Coverage;
- Restorative therapies to maintain chronic level of care are excluded from Coverage;
- Therapies which are available in a school program or similar programs available through state and local funding are excluded from Coverage;
- Recreation therapies including art, dance, music, exercise, equine, or sleep therapies are excluded from Coverage;
- Driver evaluations as part of occupational therapy are excluded from Coverage;
- Driver Training is excluded from Coverage;
- Functional capacity testing to return to work is excluded from Coverage;
- Work hardening programs are excluded from Coverage.

**Transplant Services** - Any organ or tissue transplant services not specifically listed as covered by the Plan are excluded from Coverage, including, but not limited to:

- Services received from Non-Contracted Providers unless Pre-authorized by the Plan;
- Services and supplies associated with screenings, searches and registries;
- Organ and tissue transplants that are considered experimental or investigative are excluded from Coverage;
- Organ and tissue transplants that are not medically necessary are excluded from Coverage.

**Travel and Transportation** - expenses are excluded from Coverage except for Medically Necessary transport and ambulance services which must be approved and authorized by the Plan.

## **U**

**Urea Breath Testing** - is excluded from Coverage.

## **V**

**Vaccines** – are excluded from Coverage unless approved by the Plan.

**Video Recording or Video Taping** of procedures is excluded from Coverage.

**Virtual Colonoscopy** - is excluded from Coverage unless approved by the Plan.

**Vision Materials** - Any vision supplies or materials not specifically listed as covered are excluded from Coverage.

**Vitiligo** – treatments by laser, light or other methods is excluded from Coverage.

## **W**

**Wigs** - or cranial prostheses as a result of hair loss for any reason are excluded from Coverage.

**Wisdom Teeth** - extraction of wisdom teeth are excluded from Coverage unless covered under a rider.

## **X**

## **Y**

## **Z**