EXCLUSIONS AND LIMITATIONS

VANTAGE/POS PRODUCTS
Small Group (2-100) Off Shop

The following is a list of Exclusions and Limitations that generally apply to all Optima Health plans. Once you are an enrolled member please refer to your Plan documents for the Exclusions and Limitations specific to your plan.

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This is a list of services that are not covered under Optima Health Plans. Services mean both medical and behavioral health (mental health) services and supplies unless We specifically tell You otherwise. We do not cover any services that are not listed in the Covered Services section unless required to be covered under state or federal laws and regulations. We do not cover any services that are not Medically Necessary. We sometimes give examples of specific services that are not covered but that does not mean that other similar services are covered. Some services are covered only if We authorize them. When We say You or Your We mean You and any of Your family members covered under the Plan. Call Member Services if You have questions.

A

Abortion is covered in the first 12 weeks of pregnancy. After 12 weeks abortion is covered if the mother's life is at risk, if there are major fetal abnormalities, or in the case of rape or incest.

Acupuncture is not covered**.**

Adaptations to Your Home, Vehicle or Office are not covered. Handrails, ramps, escalators, elevators, or any other changes because of a medical condition or disability are not covered.

Ambulance Service for transportation for services that are not Emergency Services is not covered unless We authorize the transportation service.

Non medical **Ancillary Services** You are referred to are not covered. Vocational rehabilitation services, employment counseling, relationship counseling for unmarried couples, pastoral counseling, expressive therapies, health education, or other non-medical services are not covered.

General **Anesthesia** in a Physician's office is not covered.

Applied Behavioral Analysis is not covered.

Aromatherapy is not covered.

Autopsies are not covered.

B

Batteries are not covered except for motorized wheelchairs and cochlear implants when authorized.

Biofeedback Therapy, neurofeedback and related testing is not covered unless We authorize it.

Birthing Center Services are covered at contracted facilities only.

Blood Donors. We do not cover any costs for finding blood donors. We do not cover the cost of transportation and storage of blood in or outside the Plan's Service Area.

Bone Densitometry Studies more than once every two years are not covered unless We authorize them.
Bone or Joint treatment involving a bone or joint of the head, neck, face or jaw is covered like any other bone or joint of the skeletal structure. The treatment must be Medically Necessary and be required because of a medical condition or injury that prevents normal function of the joint or bone.

Botox injections are not covered unless We have approved them.

Breast Augmentation or Mastopexy is not covered unless We authorize them. Cosmetic procedures or surgery for breast enlargement or reduction are not covered. Procedures for correction of cosmetic physical imperfections are not covered. Breast implants are not covered. This does not apply to procedures required by State or Federal law for breast reconstruction and symmetry following mastectomy.

Breast Ductal Lavage is not covered.

Breast Milk from a donor is not covered.

C

Chelation Therapy is not covered except for arsenic, copper, iron, gold, mercury or lead poisoning.

Circumcision is not covered after age six weeks unless Medically Necessary.

Cold Therapy Machine is not covered.

Cosmetic Surgery and Cosmetic Procedures are not covered. We do not cover medical, surgical, and mental health services for or related to cosmetic surgery or cosmetic procedures. Emotional conflict or distress does not cause a service or procedure to be Medically Necessary. **We will not cover any of the following:**

- surgery, reconstructive surgery, or other procedures that are cosmetic and not Medically Necessary to restore function or alleviate symptoms which can effectively be treated non-surgically;
- any service or supply that is a direct result of a non-covered service;
- breast augmentation or mastopexy procedures for 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 or office visits for obtaining cosmetic or experimental procedures;
- penile implants;
- vitiligo or other cosmetic skin condition treatments by laser, light or other methods.

Costs of Services paid for by Another Payor or insurance carrier are not covered. We do not cover 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. If You 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 You received services in accordance with the Plan's authorization procedures. We will not cover the cost of services that were denied by the above insurance programs for failure to meet administrative or filing requirements.

Court ordered examinations or treatments are not covered unless they are determined to be medically necessary and We have authorized them.

Custodial or **residential care** in a skilled nursing facility or other facility is not covered except for hospice care.

D

Dentistry/Oral Surgery/Dental Care
The following services are not covered. This exclusion does not apply to services covered under the Plan's Pediatric Oral Care Benefit:

- treatment of natural teeth due to disease
- routine dental care and routine dental x-rays
- dental supplies
- extraction of erupted or impacted wisdom teeth
- oral surgeries or periodontal work on the hard and/or soft tissue supporting the teeth to help support structures
- periodontal, prosthodontal, or orthodontic care
- Cosmetic services to restore appearance
- Restorative services and supplies necessary to treat, repair or replace sound natural teeth are not covered
- Dental implants or dentures and any preparation work for them are not covered.
- Dental services performed in a hospital or any outpatient facility are not covered. This does not include covered services listed under "Hospitalization and Anesthesia for Dental procedures."
- Oral surgery which is part of an orthodontic treatment program is not covered.

Disposable Medical Supplies are not covered. Medical dressings, disposable diapers, over the counter supplies, bandages, tape, gauze pads, alcohol, iodine, peroxide and other disposable supplies are not covered.

Donor Searches for organ and tissue transplants, including compatibility testing or potential donors who are not immediate blood-related family members are not covered.

Driver Training is not covered.

Drugs for certain clinical trials are not covered.

The following are not covered. Durable Medical Equipment (DME), appliances, devices, and medical supplies that have both a non-therapeutic and therapeutic use, including exercise equipment; air conditioners, purifiers, and humidifiers; hypoallergenic bed lines; whirlpool baths and hot tubs; handrails, ramps, elevators, and stair glides; telephones; adjustments made to vehicles; foot orthotics; changes made to home or businesses; or repair or replacement of equipment lost or damaged through neglect. Durable Medical Equipment not appropriate for use in the home is not covered.

E

Electron Beam Computer Tomography (EBCT) is not covered.

Services, treatment or testing required to complete **Educational Programs,** degree requirements, or residency requirements are not covered.

Educational Testing, Evaluation, Screening, or tutorial services are not covered. Any other service related to school or classroom performance is not covered**.** This does not include services that qualify as Early Intervention Services or when received as part of a covered wellness visit or screening.

Examinations, testing or treatment required for employment, insurance, or judicial or administrative proceedings are not covered.

Exercise Equipment is not covered. We do not cover bicycles, treadmills, stair climbers, free weights, exercise videos, or any other exercise equipment. We do not cover pool, gym, or health club membership fees.

Experimental or Investigative drugs, devices, treatments, or services are not covered. This does not apply to Covered Services for Clinical Trials. **Experimental or Investigative means any of the following situations:**

- 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 United States Food and Drug Administration (FDA); or
- the drug, device, medical treatment or procedure is currently under study in a **Non-FDA approved** Phase I or 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 Examinations required for work are not covered. Corrective or protective eyewear required for work is not covered.

Eye Movement Desensitization and Reprocessing Therapy is not covered.

Eye Corrective Surgery such as Radial Keratotomy, PRK, or LASIK, is not covered.

F

We **do not cover** any of the following **Foot Care Services** except for Members with Diabetes or severe vascular problems:

- removal of corns or calluses;
- nail trimming;
- treatment and services for or from flat-feet, fallen arches, weak feet, or chronic foot strain;
- foot Orthotics of any kind;
- customized or non-customized shoes, boots, and inserts.

G

Gender reassignment surgery is not covered.

GIFT programs (Gamete Intrafallopian Transfer) are not covered.

Group Speech Therapy is not covered.

Growth Hormones are only covered under the Plan's Outpatient Prescription Drug benefit. Growth hormones for the treatment of idiopathic short stature are not covered**.**

H

Health club memberships, health spa charges, exercise equipment or classes, charges from a physical fitness instructor or personal trainer, and other charges for services, equipment or facilities for developing or maintaining physical fitness, are not covered. This exclusion applies even when services are ordered by a physician.

Hearing Aids are not covered. Fittings, molds, batteries or other supplies are not covered. This does not apply to cochlear implants.

Home Births are not covered. The Plan's provider network does not include midwives. Delivery by midwife is only covered at In-network Plan participating birthing centers.

Home Health Care Skilled Services are not covered unless You are homebound**.** Services are limited as stated on Your Plan's face sheet or schedule of benefits. We do not cover any services after You have reached Your Plan's limit. We only cover services or supplies listed in Your home health care plan. We do not cover custodial care. We do not cover transportation. We do not cover homemaker services, food and home delivered meals.

Hospital Services listed below are not covered:

- Guest Meals;
- Telephones, televisions, and other convenience items;
- Private inpatient hospital rooms are not covered unless You need a private room because You have a highly contagious condition or are at greater risk of contracting an infectious disease because of Your medical condition.
- Care by interns, residents, house physicians, or other facility employees that are billed separately from the facility.

Hypnotherapy is not covered.

I

Immunizations required for foreign travel or for employment are not covered unless included under the Plan's preventive care benefits.

Implants for cosmetic breast enlargement are not covered. We do not cover cosmetic procedures or cosmetic surgery for breast enlargement or reduction. We do not cover procedures for correction of cosmetic physical imperfections. This does not apply to procedures required by State or Federal law for breast reconstruction and symmetry following mastectomy.

Infertility Services listed below are not covered:

- services, tests, medications, and treatments for the diagnosis or treatment of Infertility not listed as covered**;**
- services, tests, medications, and treatments for the enhancement of conception;
- in-vitro Fertilization programs;
- artificial insemination or any other types of artificial or surgical means of conception;
- drugs administered in connection with infertility procedures;
- GIFT/ZIFT programs;
- reproductive material storage;
- treatment or testing related to sexual organ function, dysfunction or inadequacies, including but not limited to, impotency;
- semen recovery or storage,
- sperm washing;
- services to reverse voluntary sterilization;
- infertility Treatment or services from reversal of sterilization;
- drugs used to treat infertility.
- Surrogate pregnancy services.

J

K

Keloids from body piercing or pierced ears are not covered.

L

Laboratory Services for Vantage HMO plans:

Laboratory Services from Non-Plan providers or laboratories are not covered. Medically Necessary Covered Services provided by a Non-Plan Provider during an Emergency, or during an authorized Admission to a Plan Facility, will be Covered under In Network benefits.

Laboratory Services for Vantage POS plans:

Laboratory Services from Non-Plan providers or laboratories are covered under Out of Network benefits only. Medically Necessary Covered Services provided by a Non-Plan Provider during an Emergency, or during an authorized Admission to a Plan Facility, will be Covered under In Network benefits.

Laser Therapy for Vitiligo **or any other cosmetic skin conditions** is not covered**.**

Lasik Surgery is not covered.

Long term custodial nursing home care is not covered.

M

Massage Therapy is not covered unless provided as part of an approved therapy program.

Maximum Benefit Limits are stated on Your Plan's Face Sheet or Schedule of Benefits. We do not cover any additional benefits after a benefit visit limit has been reached.

Medical Equipment, Devices and Supplies that are disposable or mainly for convenience are not covered. **We do not cover any of the following:**

- exercise equipment;
- air conditioners, purifiers, humidifiers and dehumidifiers,
- whirlpool baths,
- hypoallergenic pillows or bed linens,
- telephones,
- handrails, ramps, elevators and stair glides;
- orthotics not approved by Us;
- changes made to vehicles, residences or places of business;
- adaptive feeding devices, adaptive bed devices;
- water filters or purification devices;
- disposable Medical Supplies such as medical dressings, disposable diapers;
- over the counter supplies, such as bandages, tape, gauze pads, alcohol, iodine, peroxide.

Medical Nutritional Therapy and nutrition counseling is not covered except when provided as part of diabetes education or when received as part of covered wellness services or screening visits, or Hospice Care. Nutritional and/or dietary supplements, except as required by law are not covered. Nutritional formulas and dietary supplements that are available over the counter and do not require a written prescription are not covered.

The following medical and **mental health/substance use disorder services** are not covered:

- inpatient stays for environmental changes;
- cognitive rehabilitation therapy;
- educational therapy;
- vocational and recreational activities;
- coma stimulation therapy;
- treatment of social maladjustment without signs of a psychiatric disorder; or remedial or special education services.

Membership Fees to pools, gyms, health clubs, or athletic clubs are not covered.

Mobile Cardiac Outpatient Telemetry - (MCOT) is not covered.

Motorized or Power Operated Vehicles or chair lifts are not covered unless authorized by the Plan.

N

Neuropsychological Services including psychological examinations, testing or treatment to obtain or keep employment or insurance, or related to judicial or administrative proceedings are not covered unless approved by the Plan.

Newborns or other children of a Covered Dependent Child are not covered.

O

Obesity surgery, services, drugs or supplies related to weight loss or dietary control are not covered. Any service or supply that is a direct result of a non-covered service is also not covered. Services to improve appearance following gastric bypass surgery, such as abdominoplasties, panniculectomies, and lipectomies are not covered.

Oral Surgery services listed below **are not covered unless covered under the Plan's Pediatric Oral Benefits**:

- oral surgery which is part of an orthodontic treatment program;
- orthodontic treatment prior to orthognathic surgery;

- dental implants or dentures and any preparation work for them;

Orthoptics or vision or visual training and any associated supplemental testing are not covered.

Out Of Network Medical, Mental Health, and Laboratory Services for Vantage HMO plans:

Out Of Network Medical, Mental Health, and Laboratory Services You receive from Non-Plan Providers are not covered. Medically Necessary Covered Services provided by a Non-Plan Provider during an Emergency, or during an authorized Admission to a Plan Facility, will be Covered under In Network benefits.

Out Of Network Medical, Mental Health, and Laboratory Services for Vantage POS plans:

Out Of Network Medical, Mental Health, and Laboratory Services You receive from Non-Plan Providers, whether referred or directed by a Plan Provider, are covered under Out of Network Benefits only. Medically Necessary Covered Services provided by a Non-Plan Provider during an Emergency, or during an authorized Admission to a Plan Facility, will be Covered under In Network benefits.

Over the counter convenience and hygienic items are not covered**.**

P

Paternity Testing is not covered.

Penile implants are not covered.

Personal comfort items are not covered. Telephones, televisions, extra meal trays, personal hygiene items, under pads, diapers, ice bags, chairs, air conditioners, water purifiers, humidifiers, dehumidifiers, saunas, swimming pools or hot tubs and any other similar items for personal comfort are not covered.

Physician Examinations <u>are limited as follows</u>:

- physicals for employment, insurance or recreational activities are not covered.
- executive physicals are not covered.
- school physicals are not covered except when You have not had a health assessment with a physician during the calendar year.
- a second opinion from a Non-Plan Provider is covered only when authorized by the Plan.
- services or supplies ordered or done by a provider not licensed to do so are not covered.

Physician's Clerical Charges are not covered**. C**harges for broken appointments, telephone calls, completion of forms, transfer of medical records, the cost of copying medical records or correspondence to other parties, and any other clerical services are not covered.

Private Duty Nursing in an Inpatient setting is not covered.

Q

R

Reconstructive surgery - is not covered unless 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. Emotional conflict or distress does not constitute Medical Necessity. Breast reconstruction following mastectomy is covered.

Residential treatment center care or care in another non-skilled settings unless the treatment setting qualifies as a substance use disorder treatment facility licensed to provide continuous, structured, 24 hour a day program of drug or alcohol treatment and rehabilitation including 24 hour a day nursing care, and services are not merely custodial, residential, or domiciliary in nature.

S

Second Opinions – For Vantage HMO plans, a second opinion from a Non-Plan Provider is covered only when authorized by the Plan. For Vantage POS plans, a second opinion from a Non-Plan Provider is covered under Out of Network Benefits only. A second opinion from a Plan Provider does not require authorization.

Services – <u>We do not cover any of the services or charges listed below.</u>

- Services for which a charge is not normally made.
- Services or supplies prescribed, performed or directed by a provider not licensed to do so.
- Services provided before Your plan effective date.

- Services provided after Your coverage ends.
- Virtual Consults except when provided by Optima Health approved providers.
- Charges for missed appointments.
- Charges for completing forms.
- Charges for copying medical records.
- Any service or supply that is a direct result of a non-covered service
- Any services, supplies, treatments, or procedures determined not to be Medically Necessary.

Skilled nursing facility stays are not covered for treatment of psychiatric conditions and senile deterioration. Inpatient services during a temporary leave from a skilled nursing facility are not covered unless authorized by the Plan. Private rooms are not covered unless Medically Necessary.

S**terilization**

- Reversal of voluntary sterilization is not covered.
- Any infertility services required because of a reversal are not covered.

T

Non-interactive **Telemedicine Services** such as Fax, telephone only conversations, or email are not covered.

Services delivered under a **TDO (Temporary Detention Order)** are not covered.

Therapies. Physical, Speech, and Occupational **Therapies** are limited as stated on Your face sheet or schedule of benefits. **The following services are not covered:**

- lessons for sign language;
- therapies available in a school program;
- therapies available through state and local funding;
- recreational or nature therapies;
- art, craft, dance, or music, therapies;
- exercise, or equine, therapies;
- sleep therapies;
- driver evaluations as part of occupational therapy;
- driver training;
- functional capacity testing needed to return to work;
- work hardening programs;
- gambling therapy

Total Body Photography is not covered.

Transplant Services. <u>We do not cover any of the following</u>:

- organ and tissue transplant services not listed as covered;
- organ and tissue transplants not medically necessary;
- organ and tissue transplants considered experimental or investigative;
- services from non-contracted providers unless pre-authorized by the plan;
- services and supplies for organ donor screenings, searches and registries.

Travel and Transportation expenses are not covered. Medically Necessary transport is covered only when approved by the Plan. Ambulance services that are not Emergency Services are only covered when approved and authorized by Us. Treatment and services, other than Emergency Services, received outside of the United States of America are not covered.

TMJ Disorder Devices including appliances for TMJ pain dysfunction are not covered.

U

Urea Breath Testing is not covered**.**

V

Vaccines are not covered unless approved by the Plan.

Video Recording or Video Taping of any covered service procedure is not covered.

Treatment of **varicose veins** or **telangiectatic dermal veins** (spider veins) when services are rendered for cosmetic purposes.

Virtual Colonoscopy is not covered unless approved by the Plan.

Adult **Vision** services or supplies are not covered unless needed due to eye surgery or accidental injury, including routine vision care and materials unless listed as covered under the Plan. Services for radial keratotomy and other surgical procedures to correct refractive defects are not covered. Keratoplasty; Lasik procedures; vision training and orthoptics are not covered. Sunglasses or safety glasses and accompanying frames are not covered.

Vitiligo Treatments by laser, light or other methods is not covered.

W

Wigs or cranial prostheses for hair loss for any reason are not covered.

Extraction of erupted or impacted **Wisdom Teeth** is not covered unless it is included as covered under the Plan's Pediatric Oral Care Benefits.

Work-related injuries or diseases when the employer must provide benefits or when that person has been paid by the employer are not covered.

X

Y

Z

OUTPATIENT PRESCRIPTION DRUG EXCLUSIONS AND LIMITATIONS

The following is a list of exclusions, Limitations that apply to Your drug benefit.

1. Medications that do not meet the Plan's criteria for Medical Necessity are excluded form Coverage.
2. Ancillary charges which result from a request for a brand name outpatient prescription drug when a generic drug is available are excluded from Coverage and do not count toward any Plan Maximum Out-of-Pocket Limit.
3. Amounts You pay for any outpatient prescription drug for any outpatient prescription drug that is excluded from Coverage will not count toward any Plan Maximum Out-of-Pocket Amount.
4. All covered outpatient prescription drugs must have been approved by the Food and Drug Administration and require a prescription either by state or federal law. Medications with no approved FDA indications are excluded from Coverage.
5. Over-the-counter (OTC) medications that do not require a Physician's authorization by state or federal law and any prescription that is available as an OTC medication are excluded from Coverage. This exclusion does not apply to OTC drugs when recommended by the U.S. Preventive Services Task Force and prescribed by a physician.
6. Some drugs require Pre-Authorization from the Plan in order to be covered. The Physician is responsible for obtaining Pre-Authorization. Benefits for Covered Services may be reduced or denied for not complying with the Plan's Pre-Authorization requirements.
7. At its sole discretions Optima Health's Pharmacy and Therapeutics Committee determines which Tier a covered drug is placed in. The Plan's Pharmacy and Therapeutics Committee is composed of physicians and pharmacists. The committee looks at the medical literature and then evaluates whether to add or remove a drug from the preferred/standard drug list. Efficacy, safety, cost, and overall disease cost are factors that are taken into consideration. The Pharmacy and Therapeutics Committee may establish monthly quantity Limits for selected medications.
8. Intrauterine devices (IUDs), and cervical caps and their insertion are covered under the Plan's medical benefits.
9. All compounded prescriptions require prior authorization and must contain at least one prescription ingredient. Compound prescription medications with ingredients not requiring a Physician's authorization by state or federal law are excluded from Coverage.
10. Non-durable disposable medical supplies and items such as bandages, cotton swabs, and durable medical equipment not listed as covered are excluded from Coverage.
11. Diabetic supplies and equipment, in-person outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes if prescribed by a health care professional legally authorized to prescribe such items under law, other than those listed as covered under this prescription drug benefit are covered under the Plan's medical benefit.
12. Immunization agents, biological sera, blood, or blood products are covered under the Plan's medical benefits.
13. Injectables (other than those self-administered and insulin) are covered under the Plan's medical benefits.
14. Medication taken or administered to the Member in the Physician's office is covered under the Plan's medical benefit.

15. Medication taken or administered in whole or in part, while a Member is a patient in a licensed Hospital is covered under the Plan's medical benefit.
16. Medications for cosmetic purposes only, including but not Limited to Retin-A for aging, are excluded from Coverage.
17. Medications for experimental indications and/or dosage regimens determined by the Plan to be experimental are excluded from Coverage.
18. Therapeutic devices or appliances, including but not Limited to support stockings and other medical/non-medical items or substances, regardless of their intended use are excluded from Coverage.
19. Drug charges exceeding the cost for the same drug in a conventional packaging (i.e., convenience packages, unit doses, blister packs, etc.) are excluded from Coverage.
20. Infertility drugs are excluded from Coverage.
21. Covered Food and Drug Administration (FDA)-approved tobacco cessation medications (including both prescription and over-the-counter medications) are limited to two 90-day treatment regimens per [calendar] [contract] year when prescribed by a health care provider.
22. Prescription or over the counter appetite suppressants and any other prescription or over the counter medication for weight loss are excluded from Coverage.

CHIROPRACTIC CARE LIMITATIONS AND EXCLUSIONS

1. The following is a list exclusions and limitations under Your benefit for Chiropractic Care Spinal Manipulation:
2. Any services or treatments that are furnished before the date the Member becomes eligible, or after the date the member ceases to be eligible under the Member's plan are not covered.
3. Services or treatments that are not approved by ASH Group as Medically Necessary, in accordance with ASH Group's Clinical Services Program are not covered. This requirement does not apply to the following services or treatments: (a) a new patient exam; (b) Urgent Services; and (c) Emergency Services.
4. Services or treatments delivered by a non-Contracted Practitioner are not covered. This does not apply for the following: (a) Emergency Services; (b) Urgent Services; (c) services that are provided pursuant to a continuity of care plan approved by ASH Group; or (d) services that are provided upon referral by ASH Group in situations where such services are not available and accessible to a Member from a Contracted Practitioner within the Service Area.
5. Services, exams, and/or treatments for conditions other than Subluxation of the Spine are not covered.
6. Any services or treatments for conditions caused by or arising out of the course of employment or covered under workers' compensation or similar laws are not covered.
7. Services provided by a chiropractor practicing outside the Service Area are not covered. This does not apply to Emergency Services or Urgent Services.
8. Services rendered in excess of visits or benefit maximums are not covered.
9. Any services provided by a person who is a Family Member are not covered. Family Member means a person who is related to the covered person in any of the following ways: spouse, domestic partner, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted, step or foster child). A Family Member also includes individuals who normally live in the covered person's household.

PEDIATRIC ORAL SERVICES EXCLUSIONS AND LIMITATIONS

The following are not Covered Benefits **unless specifically identified** as a Covered Benefit:

1. Services or supplies that are not considered Dental Services are not covered under the Pediatric Oral benefit.
2. Services or treatment provided by someone other than a licensed Dentist or a qualified licensed dental hygienist working under the supervision of a Dentist are not covered.
3. A Dental Service that is determined not to be necessary or customary for the diagnosis or treatment of Your condition will not be covered. In making this determination, the Plan will take into account generally accepted dental practice standards based on the Dental Services provided. In addition, each Covered Benefit must demonstrate Dental Necessity. Dental Necessity is determined in accordance with generally accepted standards of dentistry.
4. Dental Services for injuries or conditions that may be covered under workers compensation, similar employer liability laws or other medical plan coverage are not covered.

5. Benefits or services that are available under any federal or state government program (subject to the rules and regulations of those programs) or from any charitable foundation or similar entity are not covered.
6. Dental Services provided before the date You enrolled under this plan are not covered.
7. Dental Services provided after the date You are no longer enrolled or eligible for coverage are not covered.
8. Except as otherwise provided, prescription and non-prescription drugs; pre-medications; preventive control programs, oral hygiene instructions, and relative analgesia are not covered under the Pediatric oral benefit. Prescription drugs may be covered under the Plan's medical benefits.
9. Charges for inpatient or outpatient hospital services; any additional fee that the Dentist may charge for treating a patient in a hospital, nursing home or similar facility are not covered under the pediatric oral benefit.
10. Charges to complete a claim form, copy records, or respond to requests for information are not covered.
11. Charges for failure to keep a scheduled appointment are not covered.
12. Charges for consultations, by phone or by other electronic means are not covered.
13. Dental Services to the extent that benefits are available or would have been available if You had enrolled, applied for, or maintained eligibility under Title XVIII of the Social Security Act (Medicare), including any amendments or other changes to that Act are not covered.
14. Complimentary services or Dental Services for which You would not be obligated to pay in the absence of the coverage under this plan or any similar coverage are not covered.
15. Services or treatment provided to an immediate family member by the treating Dentist are not covered. This would include a Dentist's parent, spouse or child.
16. Dental Services and supplies for the replacement device or repeat treatment of lost, misplaced or stolen prosthetic devices including space maintainers, bridges and dentures (among other devices) are not covered.
17. Cosmetic surgery or dentistry for cosmetic purposes is not covered.
18. Replacement of congenitally missing teeth by dental implant, fixed or removable prosthesis whether the result of a medical diagnosis including but not limited to hereditary ectodermal dysplasia or not related to a medical diagnosis is not covered under the Pediatric Oral benefit.
19. Experimental or investigative dental procedures, services, supplies as well as services and/or procedures due to complications thereof are not covered. Experimental or investigative procedures, services or supplies are those which, in the judgment of the Delta Dental: (a) are in a trial stage; (b) are not in accordance with generally accepted standards of dental practice, or (c) have not yet been shown to be consistently effective for the diagnosis or treatment of the Enrollee's condition.
20. Dental Services for restoring tooth structure lost from wear (abrasion, erosion, attrition, or abfraction), for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth are not covered.
21. Dental Services, procedures and supplies needed because of harmful habits are not covered. An example of a harmful habit includes clenching or grinding of the teeth.
22. Amounts assessed on dental services and/or supplies by state or local regulation are not covered.
23. Non-medically necessary orthodontic treatment is not covered.

PEDIATRIC VISION CARE AND SERVICES EXCLUSIONS AND LIMITATIONS

The following are excluded or limited under this Pediatric Vision Services Benefit:

1. Orthoptic or vision training, subnormal vision aids and any associated supplemental testing are not covered.
2. Aniseikonic lenses are not covered.
3. Medical and/or surgical treatment of the eye, eyes or supporting structures are covered under the Optima Health Medical Benefit.
4. Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment is not covered.
5. Safety eyewear is not covered.

6. Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof is not covered.
7. Plano (non-prescription) lenses and/or contact lenses are not covered.
8. Non-prescription sunglasses are not covered.
9. Two pair of glasses in lieu of bifocals are not covered.
10. Services rendered after the date an Insured Person ceases to be covered under the Policy are not covered, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order.
11. Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.
12. For Vantage HMO plans Services received Out-of-Network from Non-Plan Providers are not covered