

Vision Limitations & Exclusions

UC ClearVision plan benefits are subject to limitations and exclusions which may affect benefits payable. See plan documents for complete details.

LIMITATIONS

Covered services are limited as detailed below.

- 1) Eye examinations – one per 12 months.
- 2) Prescription eyeglass lenses or contact supply (instead of eyeglass lenses) – one per 12 months.
- 3) Prescription lense enhancements – one per 12 months.
- 4) Eyeglass frames – one per 24 months.
- 5) Low vision services, if covered – Two supplemental tests per 12 months.

EXCLUSIONS

There are no benefits for professional services or materials connected with:

- 1) Services and/or materials not specifically included in this Schedule as Covered Services.
- 2) Orthoptics or vision training and any associated supplemental testing.
- 3) Plano lenses (lenses with refractive correction of less than a $\pm .50$ diopter power)
- 4) Two pair of glasses in lieu of bifocals.
- 5) Replacement of lenses and frames furnished under this Policy that are lost, stolen, or broken, except at the normal intervals specified for Covered Services.
- 6) Medical or surgical treatment of the eyes.
- 7) Corrective vision treatment of an Experimental Nature.
- 8) Costs for services and/or materials that exceed Covered Service allowances or that are provided more frequently than specified for Covered Services.
- 9) Refitting of contact lenses after the initial 90-day fitting period.
- 10) Contact lens modification, polishing, or cleaning.
- 11) Local, state and/or federal taxes, except where Company is required by law to pay
- 12) Services associated with Corneal Refractive Therapy (CRT) or Orthokeratology
- 13) Materials and/or services covered by other group insurance or managed care plans as determined through Coordination of Benefits procedure described in the Certificate of Insurance.
- 14) Fees for broken appointments or returned checks for payment of services or materials.

THIS PLAN DOES NOT MEET THE MINIMUM ESSENTIAL HEALTH BENEFIT REQUIREMENTS FOR PEDIATRIC ORAL HEALTH AS REQUIRED UNDER THE FEDERAL AFFORDABLE CARE ACT.

Exclusions and Limitations may differ by state as specified below. Only American Dental Association procedure codes are covered.

EXCLUSIONS

The following services, supplies or charges are excluded:

1. Started prior to the Member's Effective Date or after the Termination Date of coverage under the Group Policy (for example but not limited to, multi-visit procedures such as endodontics, crowns, bridges, inlays, onlays, and dentures).

2. For house or hospital calls for dental services and for hospitalization costs (facility-use fees).

3. That are the responsibility of Workers' Compensation or employer's liability insurance, or for treatment of any automobile-related injury in which the Member is entitled to payment under an automobile insurance policy. The Company's benefits would be in excess to the third-party benefits and therefore, the Company would have right of recovery for any benefits paid in excess.

For Group Policies issued and delivered in Georgia, Missouri and Virginia, only services that are the responsibility of Workers' Compensation or employer's liability insurance shall be excluded from this Plan.

For Group Policies issued and delivered in North Carolina, services or supplies for the treatment of an Occupational Injury or Sickness which are paid under the North Carolina Workers' Compensation Act are excluded only to the extent such services or supplies are the liability of the employee according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.

For Group Policies issued and delivered in Maryland, this exclusion does not apply.

4. For prescription and non-prescription drugs, vitamins or dietary supplements. For Group Policies issued and delivered in Arizona and New Mexico, this exclusion does not apply.

5. Administration of nitrous oxide and/or IV sedation, unless specifically indicated on the Schedule of Benefits.

For Group Policies issued and delivered in Washington, this exclusion does not apply when required dental services and procedures are performed in a dental office for covered persons under the age of seven (7) or physically or developmentally disabled.

For Group Policies issued and delivered in New York, this exclusion does not apply if dental services are required for sound teeth as a result of accidental injury.

6. Which are Cosmetic in nature as determined by the Company (for example but not limited to, bleaching, veneer facings, personalization or characterization of crowns, bridges and/or dentures).

For Group Policies issued and delivered in New York, this exclusion does not apply if dental services are required for sound teeth as a result of accidental injury.

For Group Policies issued and delivered in New Jersey, this exclusion does not apply for Cosmetic services for newly born children of Members.

For Group Policies issued and delivered in Washington, this exclusion does not apply in the instance of congenital abnormalities for covered newly born children from the moment of birth.

7. Elective procedures (for example but not limited to, the prophylactic extraction of third molars).

8. For congenital mouth malformations or skeletal imbalances (for example but not limited to, treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery including orthodontic treatment).

For Group Policies issued and delivered in Kentucky, Minnesota and Pennsylvania, this exclusion shall not apply to newly born children of Members including newly adoptive children, regardless of age.

For Group Policies issued and delivered in Colorado, Hawaii, Indiana, Missouri, New Jersey and Virginia, this exclusion shall not apply to newly born children of Members.

For Group Policies issued and delivered in Florida, this exclusion shall not apply for diagnostic or surgical dental (not medical) procedures rendered to a Member of any age.

For Group Policies issued and delivered in Washington, this exclusion shall not apply in the instance of congenital abnormalities for covered newly born children from the moment of birth.

9. For dental implants and any related surgery, placement, restoration, prosthetics (except single implant crowns), maintenance and removal of implants unless specifically covered under the Certificate.

10. Diagnostic services and treatment of jaw joint problems by any method unless specifically covered under the Certificate. Examples of these jaw joint problems are temporomandibular joint disorders (TMD) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to the joint.

For Group Policies issued and delivered in New York, diagnostic services and treatment of jaw joint problems related to a medical condition are excluded unless specifically covered under the Certificate. These jaw joint problems include but are not limited to such conditions as temporomandibular joint disorder (TMD) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to the joint.

For Group Policies issued and delivered in Florida, this exclusion does not apply to diagnostic or surgical dental (not medical) procedures for treatment of temporomandibular joint disorder (TMD) rendered to a Member of any age as a result of congenital or developmental mouth malformation, disease or injury and such procedures are covered under the Certificate or the Schedule of Benefits.

For Group Policies issued and delivered in Minnesota, this exclusion does not apply.

11. For treatment of fractures and dislocations of the jaw.

For Group Policies issued and delivered in New York, this exclusion does not apply if dental services are required for sound teeth as a result of accidental injury.

12. For treatment of malignancies or neoplasms.

13. Services and/or appliances that alter the vertical dimension (for example but not limited to, full-mouth rehabilitation, splinting, fillings) to restore tooth structure lost from attrition, erosion or abrasion, appliances or any other method.

14. Replacement or repair of lost, stolen or damaged prosthetic or orthodontic appliances.

15. Preventive restorations.

16. Periodontal splinting of teeth by any method.

17. For duplicate dentures, prosthetic devices or any other duplicative device.

18. For which in the absence of insurance the Member would incur no charge.

19. For plaque control programs, tobacco counseling, oral hygiene and dietary instructions.

20. For any condition caused by or resulting from declared or undeclared war or act thereof, or resulting from service in the National Guard or in the Armed Forces of any country or international authority.

For Group Policies issued and delivered in Oklahoma, this exclusion does not apply.

21. For treatment and appliances for bruxism (night grinding of teeth).

Dental Exclusions & Limitations

22. For any claims submitted to the Company by the Member or on behalf of the Member in excess of twelve (12) months after the date of service.

For Group Policies issued and delivered in Maryland, failure to furnish the claim within the time required does not invalidate or reduce a claim if it was not reasonably possible to submit the claim within the required time, if the claim is furnished as soon as reasonably possible, and, except in the absence of legal capacity of the Member, not later than one (1) year from the time the claim is otherwise required.

23. Incomplete treatment (for example but not limited to, patient does not return to complete treatment) and temporary services (for example but not limited to, temporary restorations).

24. Procedures that are:

- Part of a service but are reported as separate services
- or reported in a treatment sequence that is not appropriate;
- or misreported or that represent a procedure other than the one reported.

25. Specialized procedures and techniques (for example but not limited to, precision attachments, copings and intentional root canal treatment).

26. Fees for broken appointments.

27. Those not Dentally Necessary or not deemed to be generally accepted standards of dental treatment. If no clear or generally accepted standards exist, or there are varying positions within the professional community, the opinion of the Company will apply.

LIMITATIONS

Covered services are limited as detailed below. Services are covered until 12:01 a.m. of the birthday when the patient reaches any stated age:

1. Full mouth x-rays – one (1) every 5 year(s).

2. Bitewing x-rays – one (1) set(s) per 12 months under age nineteen (19) and one (1) set(s) per 18 months age nineteen (19) and older.

3. Oral Evaluations:

- Comprehensive and periodic – two (2) of these services per 12 months. Once paid, comprehensive evaluations are not eligible to the same office unless there is a significant change in health condition or the patient is absent from the office for three (3) or more year(s).
- Limited problem focused and consultations – one (1) of these services per dentist per patient per 12 months.
- Detailed problem focused – one (1) per dentist per patient per 12 months per eligible diagnosis.

4. Prophylaxis – two (2) per 12 months. One (1) additional for Members under the care of a medical professional during pregnancy.

5. Fluoride treatment – one (1) per 12 months under age fourteen.

6. Space maintainers – one (1) per five (5) year period for Members under age fourteen (14) when used to maintain space as a result of prematurely lost deciduous molars and permanent first molars, or deciduous molars and permanent first molars that have not, or will not, develop.

7. Sealants – one (1) per tooth per 3 year(s) under age sixteen (16) on permanent first and second molars.

8. Prefabricated stainless steel crowns – one (1) per tooth per lifetime for Members under age fifteen (15).

9. Periodontal Services:

- Full mouth debridement – one (1) per lifetime.
- Periodontal maintenance following active periodontal therapy – two (2) per 12 months in addition to routine prophylaxis.
- Periodontal scaling and root planing – one (1) per 24 months per area of the mouth.
- Surgical periodontal procedures – one (1) per 36 months per area of the mouth.
- Guided tissue regeneration – one (1) per tooth per lifetime.

10. Replacement of restorative services only when they are not, and cannot be made, serviceable:

- Basic restorations – not within 24 months of previous placement of any basic restoration.
- Single crowns, inlays, onlays – not within 5 year(s) of previous placement of any of the procedures in this category.
- Buildups and post and cores – not within 5 year(s) of previous placement of any of the procedures in this category.
- Replacement of natural tooth/teeth in an arch – not within 5 year(s) of a fixed partial denture, full denture or partial removable denture.

11. Denture relining, rebasing or adjustments are considered part of the denture charges if provided within 6 months of insertion by the same dentist. Subsequent denture relining or rebasing limited to one (1) every 3 year(s) thereafter.

12. Pulpal therapy – one (1) per primary tooth per lifetime only when there is no permanent tooth to replace it. Eligible teeth limited to primary anterior teeth.

13. Root canal retreatment – one (1) per tooth per lifetime.

14. Recementation – one (1) per 3 year(s). Recementation during the first 3 year(s) following insertion of any preventive, restorative or prosthodontics service by the same dentist is included in the preventive, restorative or prosthodontics service benefit.

15. An alternate benefit provision (ABP) will be applied if a covered dental condition can be treated by means of a professionally acceptable procedure which is less costly than the treatment recommended by the dentist. The ABP does not commit the member to the less costly treatment. However, if the member and the dentist choose the more expensive treatment, the member is responsible for the additional charges beyond those allowed under this ABP. For example: The policy provides an allowance for an amalgam restoration on a posterior tooth. If the member chooses a composite filling, then the member will owe the difference between the allowance for the amalgam filling and the provider's charge. The provider can bill their full charge on an alternate benefit procedure.

16. Payment for orthodontic services, if covered, shall cease at the end of the month after termination by the Company. This limitation does not apply to Group Policies issued and delivered in Maryland.

17. Intraoral Films:

- Periapical – four (4) per 12 months per dentist if not performed in conjunction with definitive procedure(s).
- Occlusal – two (2) per 12 months under age eight (8).

18. General anesthesia and IV sedation: a total of sixty (60) minutes per session.