SECTION 17
EXCLUSIONS AND LIMITATIONS

17.1 General Exclusions
Coverage is not provided for:

A. Any services, tests, procedures, or supplies which CareFirst BlueChoice determines are not necessary for the prevention, diagnosis, or treatment of the Member's illness, injury, or condition. Although a service or supply may be listed as covered, benefits will be provided only if it is Medically Necessary and appropriate in the Member's particular case.

B. Any treatment, procedure, facility, equipment, drug, drug usage, device, or supply which is Experimental/Investigational, or not in accordance with accepted medical or psychiatric practices and standards in effect at the time of treatment, except for covered benefits for clinical trials.

C. The cost of services that:

1. Are furnished without charge; or

2. Are normally furnished without charge to persons without health insurance coverage; or

3. Would have been furnished without charge if a Member were not covered under the [Evidence of Coverage; Agreement] or under any health insurance.

This exclusion does not apply to:

a) Medicaid;

b) Care received in a Veteran's hospital unless the care is rendered for a condition that is a result of a Member's military service.

D. Any service, supply, drug or procedure that is not specifically listed in the Member's In-Network [Evidence of Coverage; Agreement] as a covered benefit or that does not meet all other conditions and criteria for coverage at the discretion of CareFirst BlueChoice. Provision of services by a Contracting Provider does not, by itself, entitle a Member to benefits if the services are not covered or do not otherwise meet the conditions and criteria for coverage.

E. Except for Emergency Services, Urgent Care, and follow-up care after emergency surgery, benefits will not be provided for any service(s) provided to a Member by Non-Contracting Providers, unless written prior authorization is specifically obtained from CareFirst BlueChoice.

F. Routine, palliative, or Cosmetic foot care (except for conditions determined to be Medically Necessary at the discretion of CareFirst BlueChoice), including flat foot conditions, supportive devices for the foot, treatment of subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toe nails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet.

G. [Routine eye examinations and vision services. This exclusion does not apply to evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration for infants, children, and adolescents and as stated in Section 3.]

H. Any type of dental care (except treatment of accidental bodily injuries, oral surgery, cleft lip or cleft palate or both, and pediatric dental services), including extractions, treatment of

cavities, care of the gums or bones supporting the teeth, treatment of periodontal abscess and periodontal disease, removal of teeth, orthodontics, replacement of teeth, or any other dental services or supplies. Benefits for accidental bodily injury are described in Section 1.16. Benefits for oral surgery are described in Section 1.17. Benefits for treatment of cleft lip, cleft palate or both are described in Section 1.18. Benefits for pediatric dental services are described in Section 2. All other procedures involving the teeth or areas and structures surrounding and/or supporting the teeth, including surgically altering the mandible or maxillae (orthognathic surgery) for Cosmetic purposes or for correction of malocclusion unrelated to a documented functional impairment are excluded.

I. Cosmetic surgery (except benefits for reconstructive breast surgery or reconstructive surgery) or other services primarily intended to correct, change, or improve appearances. Cosmetic means a service or supply which is provided with the primary intent of improving appearances and not for the purpose of restoring bodily function or correcting deformity resulting from disease, trauma, or previous therapeutic intervention as determined by CareFirst BlueChoice.

J. Treatment rendered by a health care provider who is the Member's Spouse, parent, child, grandparent, grandchild, sister, brother, great grandparent, great grandchild, aunt, uncle, niece, or nephew, or resides in the Member's home.

K. All non-Prescription Drugs, medications, biologicals, and Over-the-Counter disposable supplies, routinely obtained without a prescription and self-administered by the Member, except as listed as a Covered Service above, including but not limited to: cosmetics or health and beauty aids, support devices, non-medical items, foot care items, first aid and miscellaneous medical supplies (whether disposable or durable), personal hygiene supplies, incontinence supplies, and Over-the-Counter medications and solutions, except for Over-the-Counter medication or supplies dispensed under a written prescription by a health care provider that is identified in the current recommendations of the United States Preventive Services Task Force that have in effect a rating of "A" or "B".

L. Foods or formulas consumed as a sole source of supplemental nutrition, except as listed as a Covered Service in this Description of Covered Services.

M. All assisted reproductive technologies including artificial insemination and intrauterine insemination, in vitro fertilization, gamete intra-fallopian tube transfer, zygote intra-fallopian transfer cryogenic preservation or storage of eggs and embryo and related evaluative procedures, drugs, diagnostic services and medical preparations related to the same.

N. Treatment of sexual dysfunctions or inadequacies including, but not limited to, surgical implants for impotence, medical therapy, and psychiatric treatment.

O. Fees and charges relating to fitness programs, weight loss, or weight control programs, physical or other programs involving such aspects as exercise, physical conditioning, use of passive or patient-activated exercise equipment or facilities and self-care or self-help training or education, except for diabetes outpatient self-management training and educational services. Cardiac rehabilitation and pulmonary rehabilitation programs are covered as described in Section 1.

P. Maintenance programs for Physical Therapy, Speech Therapy, and Occupational Therapy for those services as stated in Section 1.7; and Cardiac Rehabilitation and pulmonary rehabilitation as stated in Section 1.10D and E.

Q. Medical or surgical treatment for obesity, weight reduction, dietary control or commercial weight loss programs, including morbid obesity. This exclusion does not apply to:

1. Well child care visits for obesity evaluation and management;

2. Evidence-based items or services for preventive care and screening for obesity that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF);

3. For infants, children, and adolescents, evidence-informed preventive care and screening for obesity provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;

4. Office visits for the treatment of childhood obesity; and

5. Professional Nutritional Counseling and Medical Nutrition Therapy as described in this Description of Covered Services.

R. Medical or surgical treatment of myopia or hyperopia, including radial keratotomy and other forms of refractive keratoplasty or any complications thereof.

S. Services that are beyond the scope of the license of the provider performing the service.

T. Services furnished as a result of a referral prohibited by law.

U. Services that are solely based on court order or as a condition of parole or probation, unless approved by CareFirst BlueChoice.

V. Health education classes and self-help programs, other than birthing classes or those for the treatment of diabetes.

W. Acupuncture services, except when approved or authorized by CareFirst BlueChoice when used for anesthesia.

X. Any service related to recreational activities. This includes, but is not limited to, sports, games, equestrian, and athletic training. These services are not covered unless authorized or approved by CareFirst BlueChoice even though they may have therapeutic value or be provided by a health care provider.

Y. Private duty nursing.

Z. Services or supplies for injuries or diseases related to a covered person's job to the extent the covered person is required to be covered by a workers compensation law.

AA. Non-medical services. including, but is not limited to:

1. Telephone consultations, failure to keep a scheduled visit, completion of forms (except for forms that may be required by CareFirst BlueChoice), copying charges or other administrative services provided by the health care provider or the health care provider's staff.

2. Administrative fees charged by a physician or medical practice to a Member to retain the physician's or medical practices services, e.g., "concierge fees" or boutique medical practice membership fees. Benefits under the [Evidence of Coverage; Agreement] are available for Covered Services rendered to the Member by a health care provider.

BB. Rehabilitation services, including Speech Therapy, Occupational Therapy, or Physical Therapy, for conditions not subject to improvement.

CC. Non-medical Ancillary Services such as vocational rehabilitation, employment counseling, or educational therapy.

DD. Services or supplies resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy, excluding no fault insurance.

EE. Transportation and travel expenses (except for Medically Necessary air and ground ambulance services, as determined by CareFirst BlueChoice, and services listed under Section 1.12, Organ and Tissue Transplants, of this Description of Covered Services), whether or not recommended by a health care provider.

FF. Services or supplies received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar persons or groups.

GG. Services, drugs, or supplies the Member receives without charge while in active military service.

HH. Habilitative Services delivered through early intervention and school services.

II. Custodial Care.

JJ. Services or supplies received before the Effective Date of the Member's coverage under the [Evidence of Coverage; Agreement].

KK. Durable Medical Equipment or Medical Supplies associated or used in conjunction with non-covered items or services.

LL. Services required solely for employment, insurance, foreign travel, school, camp admissions or participation in sports activities.

MM. Work Hardening Programs. Work Hardening Program means a highly specialized rehabilitation program designed to simulate workplace activities and surroundings in a monitored environment with the goal of conditioning the participant for a return to work.

NN. Chiropractic services or spinal manipulation treatment other than spinal manipulation treatment for musculoskeletal conditions of the spine.

17.2 Pediatric Dental Services

A. Limitations

1. Covered Dental Services must be performed by or under the supervision of a Dentist with an active and unrestricted license, within the scope of practice for which licensure or certification has been obtained.

2. Benefits will be limited to standard procedures and will not be provided for personalized restorations or specialized techniques in the construction of dentures, including precision attachments and custom denture teeth.

3. If a Member switches from one Dentist to another during a course of treatment, or if more than one Dentist renders services for one dental procedure, CareFirst BlueChoice shall pay as if only one Dentist rendered the service.

4. CareFirst BlueChoice will reimburse only after all dental procedures for the condition being treated have been completed (this provision does not apply to orthodontic services).

5. In the event there are alternative dental procedures that meet generally accepted

standards of professional dental care for a Member's condition, benefits will be based upon the lowest cost alternative procedure.

B. Exclusions
Benefits will not be provided for:

1. Replacement of a denture or crown as a result of loss or theft.

2. Replacement of an existing denture or crown that is determined by CareFirst BlueChoice to be satisfactory or repairable.

3. Replacement of dentures, implants, metal and/or porcelain crowns, inlays, onlays, pontics and crown build-ups within 60 months from the date of placement or replacement for which benefits were paid in whole or in part under the terms of the [Evidence of Coverage; Agreement] and are judged by CareFirst BlueChoice to be adequate and functional.

4. Gold foil fillings.

5. Periodontal appliances.

6. Oral orthotic appliances, unless specifically listed as a Covered Dental Service.

7. Bacteriologic studies, histopathologic exams, accession of tissue, caries susceptibility tests, diagnostic radiographs, and other pathology procedures, unless specifically listed as a Covered Dental Service.

8. Intentional tooth reimplantation or transplantation.

9. Interim prosthetic devices, fixed or removable and not part of a permanent or restorative prosthetic service.

10. Additional fees charged for visits by a Dentist to the Member's home, to a hospital, to a nursing home, or for office visits after the Dentist's standard office hours. CareFirst BlueChoice shall provide the benefits for the dental service as if the visit was rendered in the Dentist's office during normal office hours.

11. Transseptal fiberotomy.

12. Orthognathic Surgery.

13. The repair or replacement of any orthodontic appliance, unless specifically listed as a Covered Dental Service.

14. Any orthodontic services after the last day of the month in which Covered Dental Services ended.

15. Separate billings for dental care services or supplies furnished by an employee of a Dentist which are normally included in the Dentist's charges and billed for by them.

16. Transitional orthodontic appliance, including a lower lingual holding arch placed where there is not premature loss of the primary molar.

17. Limited or complete occlusal adjustments in connection with periodontal surgical treatment when received in conjunction with restorative service on the same date of service.

18. Provision splinting, intracoronal and extracoronal.

19. Endodontic implant.

20. Fabrication of athletic mouthguard.

21. Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth.

22. Adjustments to maxillofacial prosthetic appliance.

23. Maintenance and cleaning of a maxillofacial prosthesis (extra or intraoral).

24. Any orthodontic services after the last day of the calendar year in which the Member turned age 19.

25. Bridges and recementation of bridges.

17.3 Pediatric Vision Services
Benefits will not be provided for the following:

A. Any pediatric vision service stated in Section 3 for Members over age 19. If Member is under age 19 at the start of the Benefit Period but turns 19 during the Benefit Period, then the Member will receive covered pediatric vision services through the rest of that Calendar Year.

B. Diagnostic services, except as listed in Section 3.

C. Services or supplies not specifically approved by the Vision Care Designee where required in this Description of Covered Services.

D. Orthoptics, vision training, and low vision aids.

E. Non-prescription (Plano) lenses and/or glasses, sunglasses or contact lenses.

F. Except as otherwise provided, Vision Care services that are strictly Cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;

G. Services and materials not meeting accepted standards of optometric practice.

H. Services and materials resulting from the Member's failure to comply with professionally prescribed treatment.

I. Office infection control charges.

J. State or territorial taxes on vision services performed.

K. Special lens designs or coatings other than those described herein.

L. Replacement of lost and/or stolen eyewear.

M. Two pairs of eyeglasses in lieu of bifocals.

N. Insurance of contact lenses.

17.4 Organ and Tissue Transplants
Benefits will not be provided for the following:

A. Non-human organs and their implantation. This exclusion will not be used to deny Medically Necessary non-Experimental/Investigational skin grafts that are covered under this Description of Covered Services.

B. Any hospital or professional charges related to any accidental injury or medical condition of the donor of the transplant material.

C. Any charges related to transportation, lodging, and meals unless authorized or approved by CareFirst BlueChoice.

D. Services for a Member who is an organ donor when the recipient is not a Member.

E. Donor search services.

F. Any service, supply, or device related to a transplant that is not listed as a benefit in this Description of Covered Services.

17.5 Inpatient Hospital Services
Coverage is not provided (or benefits are reduced, if applicable) for the following:

A. Private room, unless Medically Necessary and/or authorized or approved by CareFirst BlueChoice. If a private room is not authorized or approved, the difference between the charge for the private room and the charge for a semiprivate room will not be covered.

B. Non-medical items and Convenience Items, such as television and phone rentals, guest trays, and laundry charges.

C. Except for covered Emergency Services and maternity care, a health care facility admission or any portion of a health care facility admission (other than Medically Necessary Ancillary Services) that had not been approved by CareFirst BlueChoice, whether or not services are Medically Necessary and/or meet all other conditions for coverage.

D. Private duty nursing.

17.6 Home Health Care Services
Coverage is not provided for:

A. Custodial Care.

[B. Services in the Member's home if it is outside the Service Area.]

C. Private duty nursing.

17.7 Hospice Care Services
Benefits will not be provided for the following:

A. Services, visits, medical equipment, or supplies not authorized by CareFirst BlueChoice.

B. Financial and legal counseling.

C. Any services for which a Qualified Hospice Care Program does not customarily charge the patient or his or her family.

D. Reimbursement for volunteer services.

E. Chemotherapy or radiation therapy, unless used for symptom control.

F. Services, visits, medical equipment, or supplies not required to maintain the comfort and manage the pain of the terminally ill Member.

G. Custodial Care, domestic, or housekeeping services.

H. Meals on Wheels or other similar food service arrangements.

I. Rental or purchase of renal dialysis equipment and supplies. Benefits for dialysis equipment and supplies are available in Section 11, Medical Devices and Supplies.

17.8 Outpatient Mental Health and Substance Abuse
Coverage is not provided for:

A. Services solely on court order or as a condition of parole or probation unless approved or authorized by the CareFirst BlueChoice Medical Director.

B. Intellectual disability, after diagnosis.

C. Psychoanalysis.

17.9 Inpatient Mental Health and Substance Abuse
Coverage is not provided for:

A. Admissions as a result of a court order or as a condition of parole or probation unless approved or authorized by the CareFirst BlueChoice Medical Director.

B. Custodial Care.

C. Admissions solely for observation or isolation.

17.10 Emergency Services and Urgent Care
Coverage is not provided for:

A. Emergency care, if the Member could have foreseen the need for the care before it became urgent (for example, periodic chemotherapy or dialysis treatment).

B. Charges for services when the claims filing and notice procedures stated in Section 10 have not been followed by the Member.

C. Except for covered ambulance services, travel, whether or not recommended by an Contracting Provider.

17.11 Medical Devices and Supplies
Benefits will not be provided for purchase, rental, or repair of the following:

A. Convenience Items
Equipment that basically serves comfort or convenience functions or is primarily for the convenience of a person caring for a Member (e.g., an exercycle or other physical fitness equipment, elevators, hoyer lifts, and shower/bath bench).

B. Furniture items, movable objects or accessories that serve as a place upon which to rest (people or things) or in which things are placed or stored (e.g., chair or dresser).

C. Exercise equipment

Any device or object that serves as a means for energetic physical action or exertion in order to train, strengthen, or condition all or part of the human body, (e.g., exercycle or other physical fitness equipment).

D. Institutional equipment
Any device or appliance that is appropriate for use in a medical facility and not appropriate for use in the home (e.g., parallel bars).

E. Environmental control equipment
Equipment that can be used for non-medical purposes, such as air conditioners, humidifiers, or electric air cleaners. These items are not covered even though they may be prescribed, in the individual's case, for a medical reason.

F. Eyeglasses or contact lenses, dental prostheses, appliances, or hearing aids (except as otherwise provided herein for cleft lip or cleft palate or both, or as stated in Section 2 and Section 3).

G. Corrective shoes (unless required to be attached to a leg brace), shoe lifts, or special shoe accessories or inserts.

H. Medical equipment/supplies of an expendable nature, except those specifically listed as covered Medical Devices and Supplies in this Description of Covered Services. Non-covered supplies include incontinence pads or ace bandages.

I. Tinnitus maskers.