OptimaHealth

EXCLUSIONS AND LIMITATIONS

Business***EDGE***® Plus Products

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

Administered by Sentara Health Plans, Inc.
V.2023 SF BE PLUS

This document lists services that are not Covered under Business***EDGE*** plans administered by Sentara Health Plans, Inc. 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 as Covered Services in the Summary Plan Description (SPD). Plans do not Cover any services that are not Medically Necessary. Examples of specific services that are shown as not Covered does not mean that other similar services are Covered. Some services are Covered only if authorized by the Plan. 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 a Covered Service in the first 12 weeks of pregnancy. After 12 weeks abortion is a Covered Service 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 a Covered Service.

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

Ambulance Service for non-emergency transportation is not a Covered Service unless authorized by the Plan.

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

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

Aromatherapy is not a Covered Service.

Autopsies are not Covered Services.

B

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

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 authorize by the Plan.

Bone or Joint treatment of the head, neck, face or jaw. The Plan does not exclude or impose limits on bone or joint treatments of the head, neck, face, or jaw that are more restrictive than limits on treatment involving any bone or joint of the skeletal structure if the treatment is required because of a medical condition or Accident/Injury which prevents normal function of the

joint or bone, and is deemed Medically Necessary to attain functional capacity of the affected part. The treatment must be Medically Necessary and be required because of a medical condition or Accident/Injury that prevents normal function of the joint or bone.

Botox injections are not Covered Services unless the Plan has approved them.

Breast Augmentation or Mastopexy is not a Covered Service unless the Plan has authorized them. Cosmetic procedures or surgery for breast enlargement or reduction are not Covered Services for correction of cosmetic physical imperfections. Breast implants are not a Covered Service. This does not apply to procedures required by State or Federal law for breast reconstruction and symmetry following mastectomy.

Breast Ductal Lavage is not a Covered Service.

Breast Milk from a donor is not a Covered Service.

C

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

Contact Lenses are not a Covered Service. Fitting of lenses or eyeglasses is not a Covered Service. Covered Services include the first pair of lenses following cataract surgery including contact lens, or placement of intraocular lens or eyeglass lens only.

Cosmetic Surgery and Cosmetic Procedures are not Covered Services. Medical, surgical, and mental health services for or related to cosmetic surgery or cosmetic procedures are not Covered Services. Emotional conflict or distress does not cause a service or procedure to be Medically Necessary. **The following are not Covered Services:**

- 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;
- Treatment or services resulting from complications due to cosmetic or experimental procedures;
- 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 unless Medically Necessary and approved by the Plan.

Costs of Services paid for by Another Payor are not Covered Services. Covered Services do not include 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 referral procedures. Covered

Services will not include 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 Services unless they are determined to be Medically Necessary and are listed as a Covered Service under the Plan

Custodial Care is not a Covered Service. The following are not Covered Services:

- Rest cures;
- Examination or care ordered by a court of law not authorized by the Plan to be provided at a Plan Provider.

D

Dentistry/Oral Surgery/Dental Care

Dentistry

- Restorative services and supplies necessary to treat, repair or replace sound natural teeth are not Covered Services.
- Covered Services include Medically Necessary dental services from an Accident/Injury. It does not matter when the Accident/Injury occurred. For Accident/Injury occurring on or after Your effective date of Coverage treatment must be sought within 60 days of the Accident/Injury.
- Covered Services include Medically Necessary dental services performed during an Emergency department visit immediately after a traumatic injury and in conjunction with the initial stabilization of the traumatic injury subject to utilization review for Medical Necessity.
- Cosmetic services to restore appearance are not Covered Services.
- Dental implants or dentures and any preparation work for them are not Covered Services.
- Dental services performed in a hospital or any outpatient facility are not Covered Services. This does not include Covered Services listed under “Hospitalization and Anesthesia for Dental procedures.”

Oral Surgery

- Oral surgery which is part of an orthodontic treatment program is not a Covered Service.
- Orthodontic treatment prior to orthognathic surgery is not a Covered Service.
- Dental implants or dentures and any preparation work for them are not Covered Services.
- Extraction of wisdom teeth is not a Covered Service.

Dental Care

- Dental care, treatment, supplies, orthodontia, extractions, repositioning, X-rays, periodontal work, or any other services dental in nature are not Covered Services.
- Dental implants or dentures and any preparation work for them are not Covered Services.

Diagnostic tests, or Diagnostic Imaging, or Surgical Procedures are not Covered Services where there is insufficient scientific evidence of the safety or efficacy of the test or procedure in improving clinical outcomes.

Disposable Medical Supplies are not Covered Services unless ordered as part of wound care and authorized by the Plan. Medical dressings, disposable diapers, over the counter supplies, bandages, tape, gauze pads, alcohol, iodine, peroxide and other disposable supplies are not Covered Services.

Driver Training is not a Covered Service.

Durable Medical Equipment (DME) is a Covered Service only up to the limits stated on Your Plan's Schedule of Benefits. DME is limited to an amount, supply or type of DME that will safely and adequately treat Your condition. Covered Services will not include any of the following:

- More than one item of DME for the same or similar purpose;
- DME and appliances not uniquely relevant to the treatment of disease;
- Disposable medical supplies and medical equipment;
- Medical dressings, disposable diapers, over the counter supplies, bandages, tape, gauze pads, alcohol, iodine, peroxide;
- DME for use in altering air quality or temperature;
- DME for exercise or training;
- DME mainly for comfort, convenience, well-being or education;
- Batteries for repair or replacement except for motorized wheelchairs or cochlear implants;
- Blood pressure monitors unless authorized by the Plan.

Drugs for certain clinical trials are not Covered Services. This includes drugs paid for directly by the clinical trial or another payor.

E

Electron Beam Computer Tomography (EBCT) is not a Covered Service. Other diagnostic imaging tests are not Covered Services where there is insufficient scientific evidence of its safety or efficacy in improving clinical outcomes.

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

Educational Testing, Evaluation, Screening, or tutorial services are not Covered Services. Any other service related to school or classroom performance is not a Covered Service. This does not include services that qualify as Early Intervention Services under the Plan's benefit or those services covered under Autism spectrum disorder benefits.

Enteral or Parenteral Feeding supplements are not Covered Services unless covered under the Plan's benefit for Medically Necessary And Enteral Nutrition Products. Over the counter supplements, over the counter infant formulas, or over the counter medical foods are not Covered Services.

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

Exercise Equipment is not a Covered Service. Bicycles, treadmills, stair climbers, free weights, exercise videos, or any other exercise equipment are not Covered Services. Pool, gym, or health club membership fees are not Covered Services.

Experimental or Investigative drugs, devices, treatments, or services are not Covered Services. 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 Services. Corrective or protective eyewear required for work is not a Covered Service.

Eye Glasses and contact lenses are not Covered Services. Fitting of lenses or eyeglasses is not a Covered Service. Covered Services are limited to the first pair of lenses following cataract surgery including contact lenses, or placement of intraocular lenses or eyeglass lenses only.

Eye Movement Desensitization and Reprocessing Therapy are not a Covered Service.

Eye Corrective Surgery such as Radial Keratotomy, PRK, LASIK, or any other eye corrective surgery is not a Covered Service.

F

The following **Foot Care Services** are not Covered Services 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 **Foot Care Services** are not Covered Services unless Medically Necessary and approved by the Plan:

- 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

Genetic Testing and Counseling are not Covered Services unless authorized by the Plan. Counseling is a Covered Service only when part of the approved genetic test unless considered preventive care.

GIFT programs (Gamete Intrafallopian Transfer) are not Covered Services.

Growth Hormones are Covered Services only under the Plan's Outpatient Prescription Drug Benefits. Growth hormones for the treatment of idiopathic short stature are not Covered Services.

H

Hearing Aids are not Covered Services. Fittings, molds, batteries or other supplies are not Covered Services.

Home Births are not Covered Services.

Home Health Care Skilled Services are not Covered unless deemed Medically Necessary and authorized by the Plan**.** Services or visits are limited as stated on Your Plan's Schedule of Benefits. We do not cover any services after You have reached Your Plan's home health visit limit. Custodial Care is not a Covered Service.

Hypnotherapy is not a Covered Service.

I

Immunizations required for foreign travel or for employment are not a Covered Service.

Implants for cosmetic breast enlargement are not a Covered Service. Cosmetic procedures or cosmetic surgery for breast enlargement or reduction are not Covered Services. Procedures for correction of cosmetic physical imperfections are not Covered Services. This does not apply to procedures required by State or Federal law for breast reconstruction and symmetry following mastectomy.

Incarceration –Services and treatments done during incarceration in a Local, State, Federal or Community Correctional Facility or prison are not Covered Services.

Infertility Treatment or Services listed below are not Covered Services.

- Services, tests, medications, and treatments for the diagnosis or treatment of Infertility not listed as a Covered Service in this SPD;
- Services, tests, medications, and treatments for the enhancement of conception;
- Services, tests, medications, and treatments that aid in or diagnose potential problems with conception not listed as a Covered Service in this SPD;
- 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 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;
- Surrogate pregnancy services;
- Drugs used to treat infertility.

J

K

Treatment of **Keloids** from body piercing or pierced ears are not Covered Services.

L

Laboratory Services from Non-Plan Providers or laboratories are Covered Services under the Plan's Out-of-Network benefits only. This does not apply to Medically Necessary Covered Services provided by a Non-Plan Provider during an Emergency, or during an authorized Admission to a Plan Facility.

M

Massage Therapy is not a Covered Service unless provided as part of an approved therapy program.

Matristem Extracellular Wound Care System is not a Covered Service.

Maximum Benefit Amounts are stated on Your Plan's Schedule of Benefits. Additional benefits after a benefit limit has been reached are not Covered Services.

Measurement of Ocular Blood Flow by Tonometer Repetitive IOP is not a Covered Service.

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 not Covered Services unless required to be covered under state or federal laws and regulations.

Medical Equipment, Devices and Supplies that are disposable or mainly for convenience are not Covered Services. **The following are not Covered Services:**

- 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 are not Covered Services except when provided as part of preventive care, diabetes education or when received as part of preventive wellness services or screening visits. Nutritional formulas and dietary supplements that are available over the counter and/or without a written prescription are not Covered Services.

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

Mobile Cardiac Outpatient Telemetry - (MCOT) is not a Covered Service.

Morbid Obesity treatment including gastric bypass surgery, other surgeries, services or drugs are not Covered Services.

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

N

Neuro-cognitive therapy is not a Covered Service.

Newborns or other children of a Covered Dependent Child are not eligible for Covered Services.

O

Obstetrical Care Home births are not Covered Services.

Oral Surgery services listed below are not Covered Services:
- 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;
- Extraction of wisdom teeth.

Orthoptics or vision or visual training and any associated supplemental testing are not covered services except when medically necessary for treatment of convergence and insufficiency. Pre-authorization is required.

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 Services under the Plan's Out-of-Network benefits only. This exclusion does not apply to Medically Necessary Covered Services provided by a Non-Plan Provider during an Emergency, or during an authorized Admission to a Plan Facility.

P

PARS System (Physical Activity Reward System) is not a Covered Service.

Pass Devices (Patient Activated Serial Stretch) are not Covered Services.

Paternity Testing is not a Covered Service.

Penile implants are not a Covered Service.

Personal comfort items are not Covered Services. 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 Services.

Physician Examinations are limited as follows:

- Physicals for employment, insurance or recreational activities are not Covered Services.
- Executive physicals are not Covered Services.
- A second opinion from a Non-Plan Provider is a Covered Service only under the Plan's Out-of-Network benefits. A second opinion by a Plan Provider does not require authorization by the Plan.
- Services or supplies ordered or done by a provider not licensed to do so are not Covered Services.

Physician's Clerical Charges are not Covered Services. Charges 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 Services.

Private Duty Nursing is not a Covered Service.

Pulsed Irrigation Evacuation System is not a Covered Service.

Q

R

Reconstructive surgery - is not a Covered Service 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. If the trauma occurred before the Member's effective date of Coverage, the reconstructive surgery is a Covered Service subject to the Plan's Medical Necessity determination. Emotional conflict or distress does not constitute Medical Necessity. Breast reconstruction following mastectomy is a Covered Service.

Remedial Education and Programs are not Covered Services. Services which are extended beyond the period necessary for the evaluation and diagnosis of learning and behavioral disabilities or for mental are not Covered Services.

Residential or Sub-Acute Level of Care or treatment is not a Covered Service unless

authorized by the Plan. Services that are merely custodial, residential, or domiciliary in nature are not Covered Services.

S

Second Opinions from Plan providers do not require authorization. A second opinion from a Non-Plan provider is a Covered Service only under the Plan's Out-of-Network benefits.

Services. The following are not Covered Services:

- 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.
- Services not listed as a covered service under this plan.
- Any service or supply that is a direct result of a non-covered service.

Spinal Manipulation is not a Covered Service.

Sterilization

- Reversal of voluntary sterilizations is not a Covered Service.
- Any infertility services required because of a reversal are not Covered Services.

T

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

Physical, Speech, and Occupational **Therapies** are limited as stated on Your Schedule of Benefits. Therapies will be Covered Services only to the extent of restoration to the level of the pre-trauma, pre-illness or pre-condition status. Covered Services do not include any of the following except for those services that are covered through Early Intervention Services or Autism spectrum disorder benefits**:**

- Therapies for developmental delay or abnormal speech pathology;
- Therapies which are primarily educational in nature;
- Special education services;
- Treatment of learning disabilities;
- Lessons for sign language;
- Therapies to correct an impairment resulting from a functional nervous disorder (i.e. stuttering, stammering);
- Therapies to maintain current status or level of care;
- Restorative therapies to maintain chronic level of care;
- 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 therapies;
- Remedial education and programs.

Total Body Photography is not a Covered Service.

Transplant Services. Covered Services do not include any of the following:
- 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;
- Services related to donor complications following a transplant.

Travel and Transportation expenses are not Covered Services. Medically Necessary transport is a Covered Service only when approved by the Plan. Elective or non-emergent ambulance 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 Covered Services under Out-of-Network benefits only.

Travel and lodging expenses are not Covered Services unless approved by the Plan related to authorized transplant services. Covered Services will not include Child care, rental cars, buses, taxis or other transportation not approved by the Plan, frequent flyer miles, or any other travel services not related to the transplant.

U

V

Video Recording or Video Taping of procedures or treatment is not a Covered Service.

Treatment of **Varicose Veins or telangiectatic dermal veins** (spider veins) for cosmetic purposed is not a Covered Service.

Vision Exams and Materials not listed as a Covered Services are not covered.

W

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

Wisdom Teeth extraction is not a Covered Service.

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

X, Y, Z

CHIROPRACTIC CARE EXCLUSIONS AND LIMITATIONS

The following is a list exclusions and limitations under Chiropractic Care benefits:

1. 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.

2. 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.

3. 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.

4. Services provided by a chiropractor practicing outside the Service Area are not covered. This does not apply to Emergency Services or Urgent Services.

5. Services rendered in excess of visits or benefit maximums are not covered.

6. 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.

7. Chiropractic services determined by ASH to be not Medically Necessary except for an initial examination and urgent services.

8. Chiropractic services determined to be experimental or investigational; procedures or services in the research stage as determined by ASH or Optima.

9. Chiropractic services not listed as a Covered Service under the Plan.

10. Hypnotherapy, behavior training, sleep therapy, and weight programs.

11. Thermography.

12. Education programs, non-medical lifestyle or self-help, or any self-help physical exercise training or related diagnostic testing.

13. Services or treatments for pre-employment physicals or vocational rehabilitation.

14. Services or treatments caused by or arising out of the course of employment or covered under public liability insurance.

15. Air conditioners, air purifiers, therapeutic mattresses, supplies, or any other similar devices or appliances.

16. Durable medical equipment, supports, orthotics, and/or prosthetics except as approved by ASH. Prescription drugs or other medicines, including a non-legend or proprietary medicine or medication not requiring a prescription order; also including topical drugs and medicines.

17. Hospitalization, anesthesia, or any inpatient or hospital or surgical facility service fees.

18. Auxiliary aids and services, including, but not limited to, interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders, and telephones compatible with hearing aids.

19. Services which do not require the supervision of or performance by a licensed Chiropractor.

20. Transportation costs to or from appointment(s).

21. Any service that is not permitted by state law with respect to the practitioner's scope of practice.

22. Treatment for conditions of the body not covered by the Optima benefit and not allowed by the applicable chiropractic scope of practice.

23. Any services provided by a person who is a family member. 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.

24. Any services rendered for elective or maintenance care including services provided to a Member whose treatment records indicate he or she has reached maximum therapeutic benefit, and Habilitative Services determined by ASH as not Medically Necessary.

25. Dietary and nutritional supplements, including vitamins; minerals; herbs, herbals and herbal products, injectable supplements and injection services, or other similar products.

26. MRI, CT scans or other advance imaging ordered by a Doctor of Chiropractic.

OUTPATIENT PRESCRIPTION DRUG EXCUSIONS AND LIMITATIONS

Outpatient Prescription Drugs

The following limitations and exclusions apply to the Plan's Prescription drug benefits.

Limitations And Other Coverage Terms.

1. You or Your means the Subscriber and each family member who is a Covered Person under the Plan.
2. Copayment and Coinsurance are out-of-pocket amounts You pay directly to the pharmacy provider for a Covered prescription drug. A Copayment is a flat dollar amount. A Coinsurance is a percent of Optima Health's Allowable Charge.
3. Deductible means the dollar amount You must pay out-of-pocket each year for Covered Services before the Plan begins to pay for Your benefits.
4. Prescriptions may be filled at a Plan pharmacy or at a non-participating pharmacy if the non-participating pharmacy or its intermediary has agreed in writing to accept as payment in full reimbursement from the Plan, including any Copayment or Coinsurance consistently imposed by the plan, at the same level as the Plan gives to participating pharmacies.
5. 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.
6. Amounts You pay for any outpatient prescription drug after a benefit Limit has been reached, or for any outpatient prescription drug that is excluded from Coverage will not count toward any Plan Maximum Out-of-Pocket Limit.
7. 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. However, the Plan may approve Coverage of limited quantities of an OTC drug. You must have a Physician's prescription for the drug, and the drug must be included on the Plan's list of covered Preferred and Standard drugs.
8. Some drugs require Pre-Authorization from the Plan in order to be covered. The Physician is responsible for obtaining Pre-Authorization. You can call Member Services at the number on Your ID card to verify that your prescription drug has been pre-authorized.
9. Unless required by law, certain Prescription Drugs may not be Covered under the Plan if You could use a "clinically equivalent drug." "Clinically equivalent drug" means a drug that for most individuals will give You similar results for a disease or condition. If You have questions about whether a certain drug is covered by the Plan please call the Member Services number on the back of Your Optima identification card. If You or Your doctor believes You need to use a different Prescription Drug, please have Your doctor contact Us. If We agree that it is Medically Necessary and appropriate we will cover the other Prescription Drug instead of the "clinically equivalent drug."
10. At its' sole discretion Optima Health's Pharmacy and Therapeutics Committee determines which Tier a covered drug is placed in or if a particular drug is included on the Plan's formulary. 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 or Your Plan's formulary. 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.
11. Intrauterine devices (IUDs), and cervical caps and their insertion are covered under the Plan's medical benefits.
12. Covered Food and Drug Administration (FDA) approved tobacco cessation medications (including both prescription and over-the-counter medications) are Limited to 90 day courses of treatment per year when prescribed by a health care provider.

Prescription Drug Coverage Exclusions

The following is a list of exclusions that apply to the Plan's prescription drug benefits.

1. Medications that do not meet the Plan's criteria for Medical Necessity are excluded from Coverage.
2. Medications with no approved FDA indications are excluded from Coverage.
3. 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.
4. 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.
5. Non-durable disposable medical supplies and items such as bandages, cotton swabs, hypodermic needles, and durable medical equipment not listed as covered are excluded from Coverage.
6. Immunization agents, other than those covered by the formulary, biological sera, blood, or blood products are excluded from Coverage.
7. Injectables (other than those self-administered and insulin) are excluded from Coverage.
8. Medication taken or administered to the Member in the Physician's office is excluded from Coverage.
9. Medication taken or administered in whole or in part, while a Member is a patient in a licensed Hospital is excluded from Coverage.
10. Medications for cosmetic purposes only, including but not Limited to Retin-A for aging, are excluded from Coverage.
11. Medications for experimental indications and/or dosage regimens determined by the Plan to be experimental are excluded from Coverage.
12. 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.
13. 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.
14. Drugs with a therapeutic over-the-counter (OTC) equivalent are excluded from Coverage unless authorized by the Plan.
15. Certain off-label drug usage is excluded from Coverage unless the use has been approved by the Plan.
16. Compound drugs are excluded from Coverage when alternative products are commercially available.
17. Cosmetic health and beauty aids are excluded from Coverage
18. Drugs purchased from Non-Plan Providers over the internet are excluded from Coverage
19. Drugs purchased through a foreign pharmacy are excluded from Coverage unless approved by the Plan for an emergency while traveling out of the country
20. Flu symptom drugs are excluded from Coverage unless approved by the Plan.
21. Human growth hormone for the treatment of idiopathic short stature are excluded from Coverage
22. Over-the-counter supplements, over-the-counter infant formulas, or over-the-counter medical foods are not Covered Services.
23. Drugs not meeting the minimum levels of evidence based on one or more of the following Standard reference compendia are not Covered Services:
    a. American Hospital Formulary Service Drug Information;
    b. National Comprehensive Cancer Network's Drugs & Biologics Compendium; or
    c. Elsevier Gold Standard's Clinical Pharmacology.

24. Minerals, fluoride, and vitamins are excluded from Coverage unless determined to be Medically Necessary to treat a specifically diagnosed Illness or when included under ACA Recommended Preventive Care.
25. Non-Sedating antihistamines are excluded from Coverage.
26. Pharmaceuticals approved by the FDA as a medical device are excluded from Coverage.
27. Drugs used to inhibit and/or suppress drowsiness, sleepiness, tiredness, or exhaustion, unless authorized by the Plan.
28. Prescriptions written by a licensed dentist are excluded from Coverage, except for the prevention of infection or pain in conjunction with a Covered dental procedure.
29. Raw powders or chemical ingredients are excluded from Coverage unless approved by the Plan or submitted as part of a compounded prescription
30. Sexual dysfunction drugs are excluded from Coverage.
31. Travel related medications, including preventive medication for the purpose of travel to other countries are excluded from Coverage.
32. Infertility drugs are excluded from Coverage.
33. Prescription or over the counter appetite suppressants and any other prescription or over the counter medication for weight loss are excluded from Coverage.
34. Abortifacient drugs that cause abortions are not covered.
35. Digital Therapeutics, including digital devices, software and applications are excluded from Coverage.
36. **This Plan uses a Closed Formulary. Any prescription drugs, over the counter drugs, or devices that are not included on the Plan's Prescription Drug Formulary are excluded from Coverage.**

Non-formulary requests. You have the right to request a non-formulary prescription drug if You believe that You need a prescription drug that is not on the Plan's list of covered drugs (formulary), or You have been receiving a specific non-formulary prescription drug for at least six months previous to the development or revision of the formulary and Your prescribing physician has determined that the formulary drug is inappropriate for Your condition or that changing drug therapy presents a significant health risk to You. Your physician must complete a medical necessity form and deliver it to the Optima Health pharmacy authorization department. After reasonable investigation and consultation with the prescribing physician, Optima Health will make a determination. Optima Health will act on such requests within one business day of receipt of the request. You will be responsible for all applicable Copayments, Coinsurance, or Deductibles depending upon which Tier a drug is placed in by the Plan.

Synchronization of Medication. For prescription drugs Covered under the Plan We will permit and apply a prorated daily cost sharing rate to prescriptions that are dispensed by an In-Network pharmacy for a partial supply if the prescribing provider or the pharmacist determines the fill or refill to be in the best interest of the Member, and the Member requests or agrees to a partial supply for the purpose of synchronizing the Member's medications. Proration will not occur more frequently than annually.

The Plan will not deny Coverage for the dispensing of a medication by an In-Network pharmacy on the basis that the dispensing is for a partial supply if the prescribing provider or the pharmacist determines the fill or refill is in the best interest of the enrollee and the enrollee requests or agrees to a partial supply for the purpose of synchronizing the Member's medications.

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Kailangan ng tulong sa ibang wika? Tawagan kami.

¿Necesita ayuda en algún otro idioma? Llámenos.

Saad łahgo át'éhígíí daa ts'í bee shíká a'doowoł nínízin. Nihich'į' hólne'.

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