EXCLUSIONS AND LIMITATIONS

OPTIMA VANTAGE/POS PRODUCTS

Small Group (2-50) 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.

Underwritten by Optima Health Plan
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This document lists services that are not Covered. 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 What is Covered section of Your Evidence of Coverage 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 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.

Acts of War, Disasters, or Nuclear Accidents - In the event of a major disaster, epidemic, war, or other event beyond our control, we will make a good faith effort to give you Covered Services. However, benefits may not be able to be provided or may be delayed in the event of a major disaster. The Plan will not be responsible for any delay or failure to give services due to lack of available Facilities or staff. Benefits will not be given for any illness or injury that is a result of war, service in the armed forces, a nuclear explosion, nuclear accident, release of nuclear energy, a riot, or civil disobedience.

Administrative Charges are not Covered, including charges or costs for:
- Completion of claim or other forms;
- Transfer or copy of medical records or reports;
- Access or concierge fees;
- Missed appointments;
- Routine telephone calls;
- Other clerical charges.

Alternative Medicine services or treatments are not Covered, including:
- Acupuncture;
- Holistic medicine;
- Homeopathic medicine;
- Hypnosis;
- Aroma therapy;
- Massage and massage therapy;
- Reiki therapy;
- Herbal, vitamin or dietary products or therapies;
- Naturopathy;
- Thermography;
- Orthomolecular therapy;
- Contact reflex analysis;
- Bioenergial synchronization technique (BEST);
- Iridology-study of the iris;
- Auditory integration therapy (AIT);
- Colonic irrigation.

Non-emergency **air, ground, water, or other Ambulance** transport services that are not Covered, unless authorized by Us.

Non-medical **Ancillary Services** are not Covered, including;
- Vocational rehabilitation services;
- Employment counseling;
- Relationship counseling for unmarried couples;
- Pastoral counseling;
- Expressive therapies;
- Health education.

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

Autopsies are not a Covered Service.

B

Batteries are not a Covered Service, except for use in:

- Motorized wheelchairs;
- Left ventricular assist device (LVAD);
- Cochlear implants.

Biofeedback Therapy, neurofeedback, and related testing are not Covered Services unless We authorize them.

Birthing Center Services are Covered at contracted Facilities only.

Searches for **Blood Donors** are not Covered.

Transportation or storage of **blood** is not Covered.

Bone Densitometry Studies more than once every two years are not Covered unless We authorize additional services.

Bone or Joint treatment is not Covered unless Medically Necessary to restore normal function of the joint or bone.

Botox injections are not Covered unless We have authorized them.

Breast Augmentation (Enlargement) or Breast Mastopexy (Breast Reduction) are not Covered unless We authorize the services. 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 a Covered Service.

Breast Milk from a donor is not a Covered Service.

C

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

Complications of Non-Covered Services are not Covered. This includes care that is needed as a direct result of a Non-Covered Service when without the Non-Covered Service, care would not have been needed.

Cosmetic Services are not Covered. This includes treatments, surgery, services, Prescription Drugs, equipment, or supplies given for cosmetic services. **We will not Cover any of the following:**

- Services to preserve, change or improve how a person looks;
- Services to change the texture or look of skin, the size, shape or look of facial or body features;
- 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 Services. 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 and Temporary Detention Orders (TDOs) are not Covered unless they are determined to be Medically Necessary and are a Covered Service under the Plan.

Custodial Care, Non-skilled Convalescent Care or Rest Cures are not a Covered. This exclusion applies even when services are recommended by a professional or performed in a Facility, such as a Hospital or skilled nursing Facility, or at home. This exclusion does not apply to hospice care.

D

Dentistry/Oral Surgery/Adult Dental Care
The following services are not Covered Services.

- Treatment of natural teeth due to disease;
- Routine dental care and routine dental X-rays;
- Dental supplies;
- Extraction of erupted or impacted wisdom teeth except to prepare the mouth for medical services and treatments;
- 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;
- Dental implants or dentures and any preparation work;
- 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;
- Orthodontic care.

Driver Training is not a Covered Service.

E

Electron Beam Computer Tomography (EBCT) is not a Covered Service.

The following **Educational services** are not Covered:

- Self-training services;
- Vocational training;
- Tutorial services or testing required to complete Educational, degree or residency requirements;
- Testing or screening services for classroom performance except when services qualify as Early Intervention Services.

Enteral or Parenteral Feeding supplements are not Covered unless included under the Plan's benefit for Medically Necessary Formula 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, unless such services are received as part of the Covered preventive care services.

Experimental or Investigative drugs, devices, treatments, or services are not Covered Services. 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 authorized 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 authorized** 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, surgery, and other services are not Covered including:
- Corrective or protective eyewear required for work;
- Eye exercise training;
- Eye Movement Desensitization and Reprocessing Therapy;
- Eye Corrective Surgery such as Radial Keratotomy, PRK, or LASIK.

F

Services provided, prescribed, ordered, or referred by Yourself or by a member of Your **family**, including Your spouse, child, brother, sister, parent, in-law are not Covered.

Palliative or cosmetic **Foot Care Services** are not Covered, including:
- Cleaning and preventive foot care when there is no illness or injury to the foot;
- Flat foot conditions;
- Foot orthotics, orthopedic and corrective shoes not part of a leg brace;
- Fitting, castings and other services related to devices of the feet, unless used for an illness affecting the lower limbs;
- Subluxations of the foot;
- Treatment or removal of corns and calluses and care of toenails except for Members with Diabetes or vascular disease;
- Fallen arches;
- Weak feet;
- Tarsalgia;
- Metatarsalgia;
- Hyperkeratoses

Free Care is not Covered. This includes services the Covered Person would not have to pay for if not Covered by this Plan such as government programs, services received from jail or prison, services from free clinics, and Workers Compensation benefits, whether or not you claim these benefits.

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.

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

H

Hearing Aids and related services are not covered, including:
- Examinations for fitting and molds;
- Hearing aid batteries except for cochlear implants;
- Other hearing aid supplies or repair services.

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 and under an approved home health care plan**.** Services and visits are limited as stated on Your schedule of benefits. We do not Cover Custodial Care unless it is part of Covered hospice care. 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 a Covered Service.

I

Immunizations required for foreign travel or for employment are not Covered, unless Covered as Preventive Care services.

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

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, when the person is not Covered under Your Plan.

J

K

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

L

For Vantage HMO plans:

Laboratory Services from Non-Plan providers or laboratories are not Covered. This exclusion does not apply to Covered Services provided by a Non-Plan Provider during an Emergency, or during an authorized Admission to a Plan Facility.

Long-Term/Custodial Nursing Home Care is not a Covered Service**.**

M

Massage Therapy is not a Covered Service, unless part of an approved medical therapy program.

Medical Equipment, Services, Exercise equipment, Devices and Supplies that are disposable, available over the counter, or for convenience are not Covered, including:
- Adaptations to Your home, car, van, other vehicle or office;
- Bicycles, treadmills, stair climbers, and other exercise equipment;
- Free weights, exercise videos and other training equipment;
- Air conditioners, purifiers, humidifiers and dehumidifiers;
- Whirlpool baths;
- Hypoallergenic pillows or bed linens;
- Under pads and diapers;

- Telephones;
- Televisions;
- Handrails, ramps, elevators, escalators, and stair glides;
- Orthotics not approved by Us;
- 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;
- Heating pads, thermometers, pulse ox meters;
- Raised toilet seats;
- Shower chairs;
- Waterbeds;
- Pools, hot tubs, or spas;
- Pool, gym or health club membership fees;
- Personal trainers or other fitness instruction;
- Ice bags;
- Chairs or recliners;
- Other personal comfort or over the counter hygienic items.

Medicare Services are not Covered for those eligible for Medicare due to age. This includes services for which benefits are payable under Medicare Parts A, B, and/or D, or would have been payable if you had applied for Parts A and/or B, except as listed in this Evidence of Coverage or as required by federal law, as described in the section titled "Medicare" in "General Provisions." If you do not enroll in Medicare Part B when you are eligible due to age, We will calculate benefits as if you had enrolled. You should sign up for Medicare Part B as soon as possible to avoid large out of pocket costs.

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

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

N

Newborns or other Children of a Covered Dependent Child are not Covered unless the grandparent Subscriber or spouse are the legal guardian or adoptive parent of that grandchild.

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 Services.

O

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.

For Vantage HMO plans:
Services or treatment You receive from **Out-of-Network Non-Plan Providers** will not be Covered, except in the following situations:

- During treatment at an In-Network hospital or other In-Network Facility You receive Covered Services from a Non-Plan Provider;
- You receive Emergency Care You get Out-of-Network from a Non-Plan Provider.

For POS plans:
Services or treatment You receive from **Out-of-Network Non-Plan Providers** will be Covered under out-of-network benefits, except in the following situations:

- If during treatment at an In-Network hospital or other In-Network Facility You receive Covered Services from an Out-of-Network Non-Plan Provider those services will be Covered under the Plan's In-Network benefits. Members are responsible for In-Network cost sharing credited toward In-Network Deductibles and Maximum Out-of-Pocket Amounts;

- Emergency Services received from Out-of-Network Non-Plan Facilities and Providers will be Covered under the Plan's In-Network benefits. Members are responsible for In-Network cost sharing credited toward In-Network Deductibles and Maximum Out-of-Pocket Amounts

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 Covered.

This policy does not provide the ACA-required minimum essential **pediatric oral health** benefits.
Penile implants are not Covered.

Physician Examinations <u>are limited as follows</u>:
- Physicals for employment, insurance or recreational activities are not Covered Services.
- Executive physicals are not Covered Services.
- 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 Services.

Private Duty Nursing in an Inpatient setting is not Covered.

Prosthetics for sports or cosmetic purposes are not Covered.

Non-Covered **Providers,** and services provided including massage therapists, physical therapist technicians, and athletic trainers.

Q

R

Reconstructive surgery is not Covered Service, unless the surgery follows a 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. This exclusion does not apply to reconstructive surgery required under the Women's Health and Cancer Rights Act.

Residential treatment center care or care in another non-skilled settings are not Covered Services 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

For Vantage HMO plans:Second Opinions – A second opinion from a Non-Plan Provider is Covered only when authorized by the Plan.

For POS plans:

Second Opinions – A second opinion from a Non-Plan Provider is only Covered under Your Out-of-Network benefits, unless authorized by the Plan.

Services – <u>We do not Cover any of the services or charges listed below.</u>
- Services deemed **Not Medically Necessary;**
- Services not listed as Covered under the Plan;
- Services not described, documented or supported in Your medical records;
- Services required for employment or continued employment;
- Services prescribed, ordered, referred by or given by a family member;
- 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;
- Services after a benefit limit has been reached
- Virtual Consults, except when provided by Optima Health authorized providers;
- Any service or supply that is a direct result of a Non-Covered service.

Sexual Dysfunction treatment, including drugs to treat sexual or erectile problems, are not Covered Services.

Skilled Nursing Facility (SNF) stays are not Covered, unless authorized by the Plan. The following services are not Covered:
- Custodial or domiciliary care;
- Rest care;
- Education or similar services;
- Private rooms unless Medically Necessary.

T

Temporomandibular Joint Treatment fixed appliances or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures) are not Covered Services.

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

Physical, Speech, and Occupational **Therapies** are limited as stated on Your Schedule of Benefits. **The following are not Covered Services:**
- Group speech therapy programs
- Lessons for sign language;
- Therapies available in a school program;
- Therapies available through state and local funding;
- Nature therapies;
- Recreational therapies, such as hobbies, arts and crafts, unless provided under a program of treatment in a licensed Residential Treatment Facility;
- Exercise, or equine, therapies;
- Driver evaluations as part of occupational therapy;
- Driver training;
- Functional capacity testing needed to return to work;
- Work hardening programs;

Total Body Photography is not a Covered Service.

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;
- **Donor Benefits** are not Covered Services if the Covered Member is donating an organ to a Non-Covered member;
- Services related to donor complications following an approved transplant are limited to Medically Necessary charges, not Covered by any other source, for up to six weeks from the date of procurement.
- Travel and lodging services not authorized by the Plan including childcare, mileage, rental cars.
- Services and supplies for organ donor screenings, searches, and registries.

Travel and Lodging, and Transportation expenses are not Covered, unless approved and authorized by Us.

Transportation by Ambulance. Ambulance services that are not Emergency Services are only Covered when approved and authorized by Us.

Treatment and services, other than Emergency Services, received while traveling outside of the United States of America are not Covered.

U

Urea Breath Testing is not a Covered Service**.**

V

Vaccines are not Covered, unless authorized by the Plan or Covered under the Plan's preventive care benefits.

Treatment of **varicose veins** or **telangiectatic dermal veins** (spider veins) are not Covered Services when considered by the Plan to be for cosmetic reasons.

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

Virtual Colonoscopy is not Covered unless approved by the Plan.

Adult **Vision care,** including routine vision exams, glasses, eyewear, services or supplies, are not Covered; except when needed due to eye surgery or accidental injury. Sunglasses or safety glasses, and accompanying frames, are not Covered Services**.**

Vitiligo Treatments by laser, light or other methods is not a Covered Service.

W

Weight Loss Surgery and Programs are not Covered Services, including:

- Drugs or supplies related to weight loss or dietary control;
- Commercial Programs, whether or not under medical supervision including, but not limited to Weight Watchers, Jenny Craig, LA Weight Loss and fasting programs;
- Weight Loss Surgery/Bariatric surgery including, but not limited to:
    - Roux-en-Y (RNY);
    - Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgeries lower stomach capacity and divert partly digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum);
    - Gastroplasty (surgeries that reduce stomach size);
    - Gastric banding procedures;
    - Cosmetic services to improve appearance following gastric bypass surgery such as abdominoplasties, panniculectomies, and lipectomies.

Wigs or cranial prostheses for hair loss are not Covered Services, except for one wig per benefit year following cancer treatment.

Extraction of erupted or impacted **Wisdom Teeth** are not Covered Services.

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

OUTPATIENT PRESCRIPTION DRUG COVERAGE EXCLUSIONS AND LIMITATIONS

The following is a list of Exclusions, Limitations and other conditions that apply to Your drug benefit. Please also see the Plan Schedule of Benefits for Member cost sharing and other Coverage terms.

Limitations.

1. 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.

2. 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 in the Plan's list of Covered Preferred or Standard drugs.
3. 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" at the non-preferred tier.
4. Our formulary is a list of FDA-approved medications that we Cover. At its sole discretion, the Optima Health Pharmacy and Therapeutics Committee reviews medications for placement onto the formulary. The Plan's Pharmacy and Therapeutics Committee is composed of Physicians and pharmacists. For all drugs, including new drugs, the committee looks at the medical literature and then evaluates whether to add or remove a drug from the formulary. Efficacy, safety, cost, and overall disease cost are factors that are taken into consideration.
5. Any Plan maximum benefit does not apply to Physician prescribed diabetic supplies covered under the Plan's prescription drug benefit or the Plan's medical benefit.
6. 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.
7. Intrauterine devices (IUDs), implants, and cervical caps and their insertion are Covered under the Plan's medical benefits.
8. Covered Food and Drug Administration (FDA) approved tobacco cessation medications (including both prescription and over-the-counter medications) are limited to two 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 Your drug benefit.

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, biological sera, blood, or blood products are excluded from Coverage.
7. Injectables (other than those self-administered and insulin) are excluded form Coverage, unless authorized by the Plan.
8. Medication taken or administered to the Member in the Physician's office is excluded from Coverage, unless authorized by the Plan.
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.
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 form 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 medical foods are excluded from Coverage under the pharmacy benefit.
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. 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.

CHIROPRACTIC CARE LIMITATIONS AND EXCLUSIONS

The following is a list exclusions and limitations under Your benefit for Chiropractic Care:

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 authorized 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 authorized 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.

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.