EXCLUSIONS AND LIMITATIONS

Plus Products

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.

This chapter lists services that are not covered. Services mean both medical and behavioral health (mental health) services and supplies unless otherwise specifically stated. The Plan does not cover any services that are not listed in this section unless required to be covered under state or federal laws and regulations. The Plan does not cover services unless they are Medically Necessary. In this section examples may be given of specific services that are covered. However, that does not mean that other similar services are covered. Some services are covered only if they have been authorized by the Plan.

A

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 We authorize the service.

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 a Covered Service.

B

Batteries are not Covered Services except for motorized wheelchairs, left ventricular assist device (LVAD) and cochlear implants when authorized.

Blood Donors. Costs for finding blood donors are not Covered Services. Costs for transportation and storage of blood in or outside the Plan's Service Area is not a Covered Service.

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

Bone or Joint treatment involving a bone or joint of the head, neck, face or jaw is covered like any other bone or joint of the skeletal structure. The treatment must be Medically Necessary and be required because of a medical condition or injury that prevents normal function of the joint or bone.

Botox injections are not Covered Services unless We have approved them.

Breast Augmentation or Mastopexy is not a Covered Service unless We have authorized them. Cosmetic procedures or surgery for breast enlargement or reduction are not Covered Services. Procedures for correction of cosmetic physical imperfections are not Covered Services. 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 for arsenic, copper, iron, gold, mercury or lead poisoning.

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

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 also 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;
- Non-medically necessary treatment or services resulting from complications due to cosmetic 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; or
- Vitiligo **or other cosmetic skin condition** treatments by laser, light or other methods.

Costs of Services paid for by Another Payor 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 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 including, but not limited to the following:**:**

- Residential care;
- Rest cures;
- Care from institutions or facilities licensed solely as intermediate care facilities, or other non-skilled sub-acute inpatient settings; or
- 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.
- 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 except for those 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 a Covered Service.
- Extraction of wisdom teeth is not a Covered Service unless Your plan includes a rider.

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 Surgical Procedures are not Covered Services where there is insufficient scientific evidence of its safety or efficacy 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 up to the limits stated on Your Plan's Face Sheet or Schedule of Benefits. Covered Services may be limited to an amount, supply, or type of DME that We determine will safely and adequately treat Your condition. **The following are not Covered Services:**

- 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;** or
- 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 where there is insufficient scientific evidence of the test's safety or efficacy in improving clinical outcomes are not Covered Services.

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 Covered Services**.** This does not include services that qualify as Early Intervention Services under the Plan's benefit; or for those services covered under Autism Spectrum Disorder benefits.

Enteral or Parenteral Feeding supplements are not Covered Services unless they are used as the sole **or major** source of nutrition. Over the counter infant formulas or 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, medical treatment or procedure is classified by the FDA as a Category B Non-experimental/investigational drug, device, or medical treatment or procedure.

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 unless the plan includes a rider for vision materials. Fitting of lenses or eyeglasses is not a Covered Service except for 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 is 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** except for Members with Diabetes or severe vascular problems:

- Removal of corns or calluses;
- Nail trimming;
- Treatment and services for or from flat-feet, fallen arches, weak feet, or chronic foot strain;
- Foot Orthotics of any kind;
- Customized or non-customized shoes, boots, and inserts.

G

Genetic Testing are not Covered Services unless We have authorized the services.
Growth Hormones are only Covered Services under the Plan's Outpatient Prescription Drug Rider. Growth hormones for the treatment of idiopathic short stature are not Covered Services**.**

H

Home Health Care Skilled Services are not Covered Services unless You are homebound, physically unable to seek care on an outpatient basis, or service is provided in lieu of inpatient hospitalization. Services or visits are limited as stated on Your Plan's Face Sheet or schedule of benefits. We do not cover any services after You have reached Your Plan's limit. We only cover services or supplies listed in Your home health care plan. Custodial Care is not a Covered Service.
Hypnotherapy is not a Covered Service.

I

Immunizations required for foreign travel or for employment are not Covered Services.
Implants for cosmetic breast enlargement are not Covered Services. 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.

J

K

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

L

M

Massage Therapy is not a Covered Service unless provided as part of an approved medical therapy program.
Matristem Extracellular Wound Care System is not a Covered Service.
Maximum Benefit Amounts are stated on Your Plan's Face Sheet or Schedule of Benefits. Additional services or treatments 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 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; or
- 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 covered 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.
Motorized or Power Operated Vehicles or chair lifts are not Covered Services unless authorized by the Plan. This does not include wheelchairs or scooters.

N
Neuro-cognitive therapy is not a Covered Service.
Newborns or other children of a Covered Dependent Child are not Covered Persons under the Plan unless the Subscriber or spouse are the legal guardian or adoptive parent, or unless mutually agreed to by the Plan and the Group.

O
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; or
- Extraction of wisdom teeth unless Your plan includes a rider.

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

Services or treatment You receive from **Out-of-Network Non-Plan Providers** will be Covered Services only under Your 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 a Non-Plan Provider those Covered Services will be covered under Your In-Network benefits;
- Emergency Care You get Out-of-Network from a Non-Plan Provider will be covered at the In-Network Copayment or Coinsurance level. Cost Sharing amounts You pay out of pocket for Out-of-Network Emergency Care will accumulate toward Your Plan's Out-of-Network Deductible 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 a Covered Service.
Paternity Testing is not a Covered Service.
Penile implants are not a Covered Service.
Personal comfort items such as, but not limited to, 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 <u>are limited as follows</u>:

- 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 when authorized by the Plan. A second opinion by a Plan Provider does not require authorization.
- 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.
Pulsed Irrigation Evacuation System is not a Covered Service.

Q

R

Reconstructive surgery is not a Covered Service unless Medically Necessary and surgery follows trauma which causes anatomic functional impairment, or is needed to correct a congenital disease or anomaly which has resulted in a functional defect. Emotional conflict or distress does not constitute Medical Necessity. Breast reconstruction following mastectomy is 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 **are not Covered Services.**
Residential or Sub-Acute Level of Care or treatment is not a Covered Service unless pre-authorized for mental health and substance use disorder treatment.

S

Second Opinions from Plan providers do not require authorization. A second opinion from a Non-Plan provider is a Covered Service only when a Plan provider is not available and authorized by the Plan.

Services – <u>The following are not Covered Services:</u>

- Services for which a charge is not normally made;
- Services or supplies prescribed, performed or directed by a provider not licensed to do so;
- Services provided before Your Plan effective date;
- Services provided after Your coverage ends;
- Virtual Consults except when provided by Optima Health approved providers;
- Charges for missed appointments;
- Charges for completing forms;
- Charges for copying medical records;
- Services not listed as a covered service under this plan; or
- Any service or supply that is a direct result of a non-covered service.

S**terilization**

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

T

Non-interactive **Telemedicine Services** such as fax, telephone only conversations, email, or online questionnaire are not Covered Services under the Plan's Telemedicine benefits.

Therapies. Physical, Speech, and Occupational **Therapies** are limited as stated on Your Face Sheet or schedule of benefits. **<u>The following are not Covered Services except for those services that are listed under Early Intervention Services or under Autism Spectrum Disorder:</u>**

- 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 or developmental nervous disorder (i.e. stuttering, stammering);
- Therapies available in a school program;
- Therapies available through state and local funding;
- Recreational or nature therapies;
- Art, craft, dance, or music therapies;
- Exercise, or equine therapies;
- Sleep therapies;
- Driver evaluations as part of occupational therapy;
- Driver training;
- Functional capacity testing needed to return to work;
- Work hardening programs;
- Gambling therapy; or
- Remedial education and programs.

Total Body Photography is not a Covered Service.
Transplant Services -<u>The following are not Covered Services</u>:

- Organ and tissue transplant services not listed as a Covered Service;
- 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;
- Out-of-Network Services are excluded from the Out-of-Network Maximum Out of Pocket Amount; or
- Services related to donor complications following a transplant.

Transportation by Ambulance. Ambulance services that are not Emergency Services are Covered Services only when approved and authorized by Us.
Travel, Lodging and other Transportation expenses are not Covered Services unless approved and authorized by Us.
Treatment and services, other than Emergency Services, received while **traveling outside of the United States of America** are Covered Services only under Your Out-of-Network benefits.

U

V
Video Recording or Video Taping of any service or procedure is not a Covered Service.
Treatment of **varicose veins** or **telangiectatic dermal veins** (spider veins) for cosmetic purposes are not Covered Services.
Virtual Consults do not include the following:

- Electronic mail message;
- Facsimile transmission; or
- Online questionnaires.

W
Wigs or cranial prostheses for hair loss for any reason are not Covered Services.
Wisdom Teeth extraction is not a Covered Service unless under a rider**.**
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

<u>OUTPATIENT PRESCRIPTION DRUG EXCUSIONS AND LIMITATIONS</u>

<u>Outpatient Prescription Drugs</u>

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

<u>Limitations And Other Coverage Terms</u>.

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. Insulin, syringes, needles, blood glucose monitors, test strips, lancets, lancet devices, and control solution are covered under the Plan's medical benefit and prescription drug benefit. Insulin pumps, pump infusion sets and supplies, and in-person outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin-using diabetes if prescribed by a health care professional legally authorized to prescribe such items under law, are covered under the Plan's medical benefit. 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.

12. Benefits will not be denied for any drug prescribed, on an inpatient or outpatient basis, to treat a covered indication so as long as the drug has been approved by the United States Food and Drug Administration for at least one indication and the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.
13. Benefits will not be denied for any drug, prescribed on an inpatient or outpatient basis, approved by the United States Food and Drug Administration for use in the treatment of cancer on the basis that the drug has not been approved by the United States Food and Drug Administration for the treatment of specific type of cancer for which the drug has been prescribed, provided the drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the standard reference compendia.
14. Benefits will not be denied for any drug, prescribed on an inpatient or outpatient basis, approved by the United States Food and Drug Administration for use in the treatment of cancer pain for the reason that the dosage is in excess of the recommended dosage of the pain relieving agent, if the prescription has been prescribed for a person with intractable cancer pain.
15. Intrauterine devices (IUDs), and cervical caps and their insertion are covered under the Plan's medical benefits.
16. 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 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. 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.
4. 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.
5. Immunization agents, biological sera, blood, or blood products not listed as covered are excluded from Coverage.
6. Injectables not listed as covered are excluded from Coverage under this rider.
7. Medication taken or administered to the Member is excluded from Coverage under this rider unless the drug is listed on the formulary.
8. Medication taken or administered in whole or in part, while a Member is a patient in a licensed Hospital is excluded from Coverage under this rider.
9. Medications for cosmetic purposes only, including but not Limited to Retin-A for aging, are excluded from Coverage.

10. Medications for experimental indications and/or dosage regimens determined by the Plan to be experimental are excluded from Coverage.
11. 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.
12. 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.
13. Drugs with a therapeutic over-the-counter (OTC) equivalent are excluded from Coverage. The Pharmacy and Therapeutics Committee may opt to cover an OTC drug if it is cost-effective.
14. Certain off-label drug usage is excluded from Coverage unless the use has been approved by the Plan.
15. Compound drugs are excluded from Coverage when alternative products are commercially available.
16. Cosmetic health and beauty aids are excluded from Coverage
17. Drugs purchased from Non-Plan Providers over the internet are excluded from Coverage
18. Drugs purchased through a foreign pharmacy are excluded from Coverage unless approved by the Plan for an emergency while traveling out of the country
19. Flu symptom drugs are excluded from Coverage unless approved by the Plan.
20. Human growth hormone for the treatment of idiopathic short stature are excluded from Coverage
21. Medical foods are excluded from Coverage. This does not apply to Medically Necessary formula and enteral nutrition products covered under the Plan's benefit for treatment for an inherited metabolic disorder for which the covered individual's physician has issued a written order stating that the formula or enteral nutrition product is Medically necessary and has been proven effective as a treatment regimen for the covered individual and that the formula or enteral nutrition product is a critical source of nutrition as certified by the physician by diagnosis.
22. 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.
23. 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.
24. Non-Sedating antihistamines are excluded from coverage unless the drug is listed on the formulary.
25. Pharmaceuticals approved by the FDA as a medical device are excluded from Coverage unless approved by the plan.
26. Drugs used to inhibit and/or suppress drowsiness, sleepiness, tiredness, or exhaustion, unless authorized by the Plan.
27. 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.
28. Raw powders or chemical ingredients are excluded from Coverage unless approved by the Plan or submitted as part of a compounded prescription

29. Sexual dysfunction drugs are excluded from Coverage unless approved by the plan.
30. Travel related medications, including preventive medication for the purpose of travel to other countries are excluded from Coverage.
31. Abortifacient drugs that cause abortions are not covered.
32. **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 48 hours 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.