



EXCLUSIONS AND LIMITATIONS

Vantage POSA and POS Products

The following is a list of Exclusions and Limitations that generally apply to all 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 We specifically tell You otherwise. We do not cover any services that are not listed in the Covered Services section 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, including abortifacient drugs, is Covered in the first 12 weeks of pregnancy. After 12 weeks, abortion is Covered if the mother's life is at risk, if there are major fetal abnormalities, or in the case of rape or incest.

Administrative Charges or fees 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 are not Covered including:

- Acupuncture;
- Holistic medicine
- Homeopathic medicine;
- Hypnosis;
- Aromatherapy;
- Massage and massage therapy;
- Reiki therapy;
- Herbal, vitamin or dietary products or therapies;
- Naturopathy;
- Thermography;
- Orthomolecular therapy;
- Contact reflex analysis;
- Bio-energetic synchronization technique (BEST);
- Iridology-study of the iris;
- Auditory integration therapy (AIT);
- Colonic irrigation.

Non-emergency **air, ground, water, or other Ambulance transport** services are not Covered unless We have approved the services.

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 Covered.

Autopsies are not Covered.

B

Batteries are not Covered except for use in:

- Motorized wheelchairs;
- Left ventricular assist device (LVAD);
- Cochlear implants;
- Hearing aids for children age 18 and under and limited to one initial set of batteries.

Biofeedback and neurofeedback therapies and related testing are not Covered unless We approve the services.

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.

Breast Augmentation (enlargement) or Breast Mastopexy (reduction) is not Covered unless We have approved 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 Milk from a donor is not Covered.

C

Chelation Therapy is not Covered unless We have approved the services.

Chiropractic Care is not a Covered Service unless Your Plan includes a rider.

Chiropractic care means diagnosis, correction, and management of vertebral subluxations or neuromusculoskeletal conditions.

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

Contact Lenses are not Covered Services. Fitting of lenses or eyeglasses is not Covered. 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. Medical, surgical, and mental health services for, or related to, cosmetic surgery or cosmetic procedures are not Covered. Emotional conflict or distress does not cause a service or procedure to be Medically Necessary. **The following are also not Covered Services:**

- 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;
- 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;

- Cosmetic Botox injections;
- Penile implants; or
- Cosmetic skin condition treatments by laser, light or other methods unless Medically Necessary.

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 and Temporary Detention Orders (TDOs) are not Covered Services unless they are determined to be Medically Necessary and are listed as a Covered Service under the Plan.

Custodial Care, Respite Care, Non-skilled Convalescent Care or Rest Cures, are not Covered Services. 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/Dental Care.

The following services are not Covered:

- Treatment of natural teeth due to disease;
- Routine dental care;
- 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, prosthodontic, 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 preparation work;
- Dental services performed in a Hospital or any outpatient facility. 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.

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

E

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

- 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 Services 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 unless We have approved them.

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

Eyeglasses 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.

F

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

The following **Foot Care Services are not Covered Services** unless Medically Necessary:

- 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.

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 We have approved the services. Counseling is a Covered Service only as part of the approved genetic test unless considered preventive care.

H

Hearing Aids and related services, including examinations, fittings, molds, batteries or other supplies or repair services, for Members over age 18 are not covered unless Your Plan has a hearing aid rider.

Home Births are not a Covered Service.

Home Health Care Skilled Services are not Covered unless Medically Necessary and We have approved the services. Services and visits are limited as stated on Your schedule of benefits. We do not Cover any services after You have reached Your Plan's benefit limit. We do not cover Custodial Care. We do not cover homemaker services, food and home delivered meals.

Hospital Services listed below are not Covered Services:

- Guest meals;
- Telephones, televisions, and other convenience items;
- Private inpatient Hospital rooms 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;

Hypnotherapy is not a Covered Service.

I

Immunizations required for foreign travel or for employment are not Covered Services.

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

Unless listed as a Covered Service in this EOC, or under a Rider, **Infertility 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;
- 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

L

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

M

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

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

Medical Equipment, Services, Exercise equipment, Devices and Supplies that are disposable, available over the counter, or mainly for convenience are not Covered Services. **The following are not Covered Services:**

- 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 and disposable diapers;
- Over the counter supplies, such as bandages, tape, gauze pads, alcohol, iodine, and peroxide;
- Heating pads;
- Thermometers;
- 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.

Morbid Obesity treatment including gastric bypass surgery, other surgeries, services or drugs are not Covered Services unless Your Plan includes these services in a rider and We have approved the services for Members who meet established criteria.

Motorized or Power Operated Vehicles or chair lifts are not Covered Services We have approved Coverage. 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 mutually agreed to by the Plan and the Group.

Nutritional and/or dietary supplements, except as required by law, are not Covered Services. 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.

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 and Air Ambulance 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 a Covered Service.

Paternity Testing is not a Covered Service.

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 unless approved 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.

Private Duty Nursing is not a Covered Service.

Prosthetics for sports or cosmetic purposes are not a Covered Service.

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 treatment center care or care in another non-skilled setting are not Covered Services when services are merely custodial, residential, or domiciliary in nature.

S

Services – The following are not Covered Services:

- Services that are 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 an immediate 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 Plan approved providers;
- Services or supplies that are a direct result of a non-covered service.

Skilled Nursing Facility (SNF) stays are not covered unless We have approved the services. The following services are not Covered:

- Custodial or domiciliary care;
- Respite Care;
- Education or similar services;
- Private rooms unless Medically Necessary.

Spinal Manipulation is not a Covered Service unless Covered under a Chiropractic Care Rider.

T

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

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

Therapies. 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. **The following are not Covered Services except for those services that are listed under Early Intervention Services or under Autism Spectrum Disorder:**

- Therapies for developmental delay or abnormal speech pathology;
- Therapies which are primarily educational in nature;
- Special education services;
- Treatment of learning disabilities;
- Group speech therapy programs;
- Lessons for sign language;
- Therapies to correct an impairment resulting from a functional or developmental 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;
- Remedial education and programs; or
- Habilitative Services.

Total Body Photography is not a Covered Service.

Transplant Services -The following are not Covered Services:

- 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;
- Travel and lodging services not approved by the Plan including childcare, mileage, and rental cars;
- Services not listed as Covered under the Plan's Transplant Services benefit; or
- 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;
- **Donor Benefits** are not Covered Services if the Covered individual is donating an organ to a non-covered member.

Transportation by Ambulance, or other transportation 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 not Covered Services.

U

V

Treatment of **varicose veins** or **telangiectatic dermal veins** (spider veins) for cosmetic purposes are not Covered Services.

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

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

OUTPATIENT PRESCRIPTION DRUG 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 on the Plan's list of Covered Preferred and 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 Plan 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 Plan 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. Intrauterine devices (IUDs), implants, and cervical caps and their insertion are Covered under the Plan's medical benefits.
7. 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.

For Plans with Open Formulary: **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 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, 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 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. Nutritional and/or Dietary Supplements, except as required by law, are not Covered Services. Nutritional formulas and dietary supplements that are available over the counter and do not require a written prescription are not Covered Services. This exclusion does not apply to Plan Covered Services under the "Medically Necessary Formula and Enteral Nutrition Products" benefits in Section 6 "What is Covered" of Your Evidence of Coverage.
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.
25. Pharmaceuticals approved by the FDA as a medical device are excluded from Coverage unless authorized 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.
30. Travel related medications, including preventive medication for the purpose of travel to other countries are excluded from Coverage.
31. Infertility drugs are excluded from Coverage.
32. Prescription or over the counter appetite suppressants and any other prescription or over the counter medication for weight loss are excluded from Coverage.
33. Abortifacient drugs that cause abortions are not covered.
34. Digital Therapeutics, including digital devices, software and application are excluded from Coverage.

For Plans with Standard (Closed) Formulary:
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 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, 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 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. Nutritional and/or Dietary Supplements, except as required by law, are not Covered Services. Nutritional formulas and dietary supplements that are available over the counter and do not require a written prescription are not Covered Services. This exclusion does not apply to Plan Covered Services under the "Medically Necessary Formula and Enteral Nutrition Products" benefits in Section 6 "What is Covered" of Your Evidence of Coverage.
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.
25. Pharmaceuticals approved by the FDA as a medical device are excluded from Coverage unless authorized 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.
30. Travel related medications, including preventive medication for the purpose of travel to other countries are excluded from Coverage.
31. Infertility drugs are excluded from Coverage.
32. Prescription or over the counter appetite suppressants and any other prescription or over the counter medication for weight loss are excluded from Coverage.

33. Digital Therapeutics, including digital devices, software and application are excluded from Coverage.
34. **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 not Covered.**

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 Plan's pharmacy authorization department. After reasonable investigation and consultation with the prescribing Physician, the Plan will make a determination. The Plan 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.