Sentara®
Health Plans

EXCLUSIONS AND LIMITATIONS

Business*EDGE*® Plus Products

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

Administered by Sentara Health Plans, Inc.
V.2027 SF BE Plus

This document 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 the "What is Covered" 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 of specific Covered Services may be given. 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

Acts of War, Disasters, or Nuclear Accidents. In the event of a major disaster, epidemic, war, or other event beyond Our control, the Plan will make a good faith effort to provide 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 provide services due to lack of available Facilities or staff.

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.

Air Ambulance will not be Covered if transported to a Facility that is not an acute care Hospital (such as a Skilled Nursing Facility), or if taken to a physician's office or personal residence. Air ambulance transport to accommodate treatment at a preferred hospital or by a preferred physician is not Covered.

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

The following non-medical **Ancillary Services** are not Covered:

- Vocational Rehabilitation services
- Employment Counseling
- Pastoral Counseling
- Expressive Therapies
- Health Education
- Other non-medical services

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

Aromatherapy is not a Covered Service.

Autopsies are not Covered Services.

B

Batteries are not Covered, except for use in the following:

- 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.]

Blood Donors. The Plan does not Cover any costs for finding blood donors. The Plan does not Cover the cost of transportation and storage of blood in or outside the Plan's Service Area.

Bone Densitometry Studies more frequently than once every two years are not Covered unless Medically Necessary and approved by the Plan.

Breast Augmentation (Enlargement) or Mastopexy (Breast Reduction) are not Covered unless the Plan has Approved the service. Cosmetic procedures or surgery for breast enlargement, breast reduction, or correction of cosmetic physical imperfections are not Covered Services. Breast Implants are not a Covered Service. This does not apply to procedures required by State or Federal Law for Breast Reconstruction and symmetry following Mastectomy.

Breast Milk from a donor is not a Covered Service.

C

Chelation Therapy is not a Covered Service unless Medically Necessary and approved by the Plan

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

Cosmetic Surgery and Cosmetic Procedures are not Covered Services. Medical, surgical, and Mental Health Services for or related to Cosmetic Surgery or procedures are not Covered Services. Procedures meant to preserve, change**,** or improve how you look, for reasons other than for Medical Necessity, are deemed Cosmetic Services. Emotional conflict or distress does not deem a service or procedure to be Medically Necessary. <u>The following are not Covered Services:</u>

- Surgery, reconstructive surgery, or other procedures that are cosmetic and not Medically Necessary to restore function or alleviate symptoms which can effectively be treated non-surgically;
- Treatment or services resulting from complications due to cosmetic or Experimental procedures;
- Breast Augmentation or Mastopexy procedures for correction of cosmetic physical imperfections, except as required by State or Federal Law regarding Breast Reconstruction and symmetry following Mastectomy;
- Tattoo removal;
- Keloid treatment as a result of the piercing of any body part;
- Consultations or office visits for obtaining cosmetic or Experimental procedures;
- Cosmetic Botox injections;
- Penile Implants; or
- Cosmetic skin condition treatments by laser, light or other methods unless Medically Necessary and approved by the Plan.

The Exclusion for Cosmetic Services does not apply to:

- Surgery or procedures to correct deformity caused by disease, trauma, or previous therapeutic process;
- Surgery or procedures to correct congenital abnormalities that cause functional impairment;
- Surgery or procedures on newborn children to correct congenital abnormalities.

Costs of Services Paid by Another Payor are not Covered Services. Covered Services do not include the cost of services, which are or may be covered through a group insurance mechanism or governmental program, such as Workers Compensation, occupational disease laws and other employers' liability laws. If You have the cost of services denied by one of the above insurance programs, the Plan will only consider payment of Covered services in those cases where You received services in accordance with the Plan's referral procedures. Covered Services will not include the cost of services that were denied by the above insurance programs for failure to meet administrative or filing requirements.

Court Ordered Examinations or Treatments and Temporary Detention Orders (TDOs) are not Covered Services unless they are determined to be Medically Necessary, include Covered Services, and are approved under the Plan

Custodial Care, Respite Care, Non-skilled Convalescent Care or Rest Cures, are not a Covered Service. 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

Dentistry

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

Oral Surgery

- Oral Surgery which is part of an orthodontic treatment program is not a Covered Service.
- Orthodontic Treatment prior to orthognathic surgery is not a Covered Service.

- Dental Implants or Dentures and any preparation work for them are not Covered Services.
- Extraction of Wisdom Teeth is not a Covered Service.

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

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

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

Driver Training is not a Covered Service.

Durable Medical Equipment (DME) is a Covered Service only up to the limits stated on Your Plan's Schedule of Benefits. DME is limited to an amount, supply or type of DME that will safely and adequately treat Your condition. Covered Services will not include any of the following:
- More than one item of DME for the same or similar purpose;
- DME and appliances not uniquely relevant to the treatment of disease;
- Disposable medical supplies and medical equipment;
- Medical dressings, disposable diapers, over-the-counter supplies, bandages, tape, gauze pads, alcohol, iodine, peroxide;
- DME for use in altering air quality or temperature;
- DME for exercise or training;
- DME mainly for comfort, convenience, well-being or education;
- Batteries for repair or replacement except for motorized wheelchairs or cochlear implants;
- Blood pressure monitors unless authorized by the Plan.

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

E

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

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

Examinations required for employment, insurance, or judicial or administrative proceedings are not Covered, unless Covered under the Plan's Preventive Care Benefits.

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. This exclusion also applies to all related services received before, during, or after the Experimental or Investigative service or treatment. The fact that a service is the only available treatment will not make it a Covered Service. "Experimental or Investigative" applies to Experimental or Investigative includes any of the following situations:

- The majority of the medical community does not support the use of this drug, device, medical treatment or procedure; or
- The use of this drug, device, medical treatment or procedure may have been shown to be unsafe and/or of no or questionable value as reported by current scientific literature and/or regulatory agencies; or
- The research regarding this drug, device, medical treatment or procedure may be so limited that an evaluation of safety and efficacy cannot be made; or
- The drug or device is not approved for marketing by the United States Food and Drug Administration (FDA); or
- The drug, device, medical treatment or procedure is currently under study in a Non-FDA approved Phase I or Phase II clinical trial, an experimental study/investigational arm of a Phase III clinical study, or otherwise under study to determine safety and efficacy or to compare its safety and efficacy to current standards of care; or
- The drug device or medical services is classified by the FDA as a Category B Non-experimental/investigational drug, device, 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.

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

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

F

Services provided, prescribed, ordered, or referred by a Covered Person's **Family Member,** including a spouse, child, brother, sister, parent, or in-law are not Covered Services.

The following **Foot Care Services** are not Covered Services unless authorized by the Plan.

- Operations which involve the exposure of bones, tendons, or ligaments for the treatment of tarsalgia, metatarsalgia or bunions;
- Treatment and services related to plantar warts.

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

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

G

Genetic Testing and Counseling are not Covered Services unless Medically Necessary and provided under the Plan's benefits for Diagnostic and Laboratory Services and Testing, Maternity and Newborn Care, or Preventive Care.

H

Hearing Aids and related services, including examinations, fittings, molds, batteries or other supplies or repair services are not Covered for Members over age 18.

Home Health Care Skilled Services are not Covered Services unless Medically Necessary and the Plan has approved the services. Services and visits are limited as stated on Your Schedule of Benefits. The Plan does not Cover any more services after the Plan's visit limit has been reached. Custodial Care is not a Covered Service. The Plan does not Cover homemaker services, food and home delivered meals. Services provided by registered nurses and other health workers who are not employees of, or working under an approved arrangement with, a Home Health Care Provider are not Covered.

Hypnotherapy is not a Covered Service.

I

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

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

Infertility Treatment or Services listed below are not Covered Services.

- Services, tests, medications, and treatments for the diagnosis or treatment of Infertility;
- 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;
- Gamete Intrafallopian Transfer (GIFT) programs;

- Zygote Intrafallopian Transfer (ZIFT) programs;
- Reproductive material storage;
- Treatment related to sexual organ function, dysfunction or inadequacies, including but not limited to, Impotency;
- Semen recovery or storage,
- Sperm washing;
- Services to reverse voluntary sterilization;
- Infertility Treatment or services from reversal of sterilization;
- Surrogate pregnancy services;
- Drugs used to treat Infertility.

J

K

L

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

M

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

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

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

- Exercise equipment;
- Air conditioners, purifiers, humidifiers and dehumidifiers,
- Whirlpool baths,
- Hypoallergenic pillows or bed linens,
- Telephones,
- Handrails, ramps, elevators and stair glides;
- Orthotics not approved by Us;
- Changes made to vehicles, residences or places of business;
- Adaptive feeding devices, adaptive bed devices;
- Water filters or purification devices;
- Disposable Medical Supplies such as medical dressings, disposable diapers;
- Over-the-counter supplies, such as bandages, tape, gauze pads, alcohol, iodine, peroxide.

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

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

N

Neuro-cognitive therapy is not a Covered Service.

Newborns or other children of a Covered Dependent Child are not Covered under the Plan, unless mutually agreed upon by both the Plan and the Group

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

O

Orthoptics or vision or visual training and any associated supplemental testing are not Covered Services, except when Medically Necessary. Pre-authorization is required.

Services or treatment received from **Out-of-Network Non-Plan Providers** will be Covered under Out-of-Network benefits, except in the following situations:

- Treatment at an In-Network hospital or other In-Network Facility included 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 provided by 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.

PASS Devices (Patient Activated Serial Stretch) are not Covered.

Paternity Testing is not a Covered Service.

Penile Implants are not a Covered Service.

Personal Comfort Items are not Covered Services. Telephones, televisions, extra meal trays, personal hygiene items, under pads, diapers, ice bags, chairs, air conditioners, water purifiers, humidifiers, dehumidifiers, saunas, swimming pools or hot tubs and any other similar items for personal comfort are not Covered Services.

Physician Examinations are limited as follows:

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

Physician's Clerical Charges are not Covered Services. Charges for broken appointments, telephone calls, completion of forms, transfer of medical records, the cost of copying medical records or correspondence to other parties, and any other clerical services are not Covered Services.

Private Duty Nursing is not a Covered Service.

Pulsed Irrigation Evacuation System is not a Covered Service.

Q

R

Reconstructive Surgery is not a Covered Service unless services follow trauma which causes anatomic functional impairment or is needed to correct a congenital disease or anomaly which has resulted in a functional defect. If the trauma occurred before the Member's Effective Date of Coverage, the reconstructive surgery is a Covered Service subject to the Plan's Medical Necessity determination. Emotional conflict or distress does not constitute Medical Necessity. Breast reconstruction following mastectomy is a Covered Service.

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

S

Services. The following are not Covered Services:
- Services for which a charge is not normally made;
- Services or supplies prescribed, performed or directed by a provider not licensed to do so;
- Services provided before the Plan Effective Date;
- Services provided after Coverage ends;
- Virtual Consults except when provided by Sentara approved providers;
- Charges for missed appointments;
- Charges for completing forms
- Charges for copying medical records.
- Services not listed as a Covered Service under this plan.
- Any service or supply that is a direct result of a non-covered service.

Spinal Manipulation is not a Covered Service.

Sterilization Reversal

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

T

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

Physical, Speech, and Occupational **Therapy Services** are limited, as stated on the Schedule of Benefits. Therapies are only Covered up to the extent necessary for restoration to the level of the pre-trauma, pre-illness or pre-condition status. Except for those services Covered under Early Intervention Services Benefit or as part of an Autism Spectrum Disorder Treatment Plan, the following are Excluded from Coverage:

- Therapies for developmental delay or abnormal speech pathology;
- Therapies which are primarily educational in nature;
- Special education services;
- Treatment of learning disabilities;
- Lessons for sign language;
- Therapies to correct an impairment resulting from a functional nervous disorder (i.e. stuttering, stammering);
- Therapies to maintain current status or level of care;
- Restorative therapies to maintain chronic level of care;
- Therapies available in a school program;
- Therapies available through state and local funding;
- Recreational or nature therapies;
- Art, craft, dance, or music therapies;
- Exercise, or equine, therapies;
- Sleep therapies;
- Driver evaluations as part of occupational therapy;
- Driver training;
- Functional capacity testing needed to return to work;
- Work hardening programs;
- Gambling therapies;
- Remedial education and programs.

Total Body Photography is not a Covered Service.

Transplant Services. Covered Services do not include any of the following:

- Organ and tissue transplant services not listed as Covered;
- Organ and tissue transplants not Medically Necessary;
- Organ and tissue transplants considered Experimental or Investigative;
- Services from non-contracted providers unless pre-authorized by the Plan;
- Services and supplies for organ donor screenings, searches and registries;
- Services related to donor complications following a transplant 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 Enrollee is donating an organ to a non-covered person
- Transplant Services outside the United States of America.

Transportation by Non-Emergency Ambulance (or other transportation service) is not Covered, unless approved and Authorized by the Plan

Travel, Lodging, and other Transportation Expenses are not Covered Services unless approved and Authorized by the Plan. This exclusion does not apply to Covered Services under the Plan's benefits for Transplant Services.

While **Traveling Outside of the United States of America**, treatment and services are not Covered, except for Emergency Services.

U

V

Treatment of **Varicose Veins or Telangiectatic Dermal Veins (Spider Veins)** for Cosmetic purposes are not Covered.

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

Vision Correction Surgery such as Radial Keratotomy, PRK, LASIK, or any other eye corrective procedure that is not Medically Necessary is not a Covered Service. This exclusion does not apply to Medically Necessary Ophthalmology procedures to treat Medical Conditions of the eye, such as Diabetes, Glaucoma, Cataracts, Retinopathy, and Corneal Erosion.

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

W

Weight Management. The Plan does not Cover prescribed medications or over-the-counter drugs for weight management.

Wigs or Cranial Prostheses for hair loss of any reason are not Covered Services.

Extraction of erupted or impacted **Wisdom Teeth** is not Covered, except when Medically Necessary to prepare the mouth for other Covered Services and treatments.

Work-Related Injuries or Diseases are not Covered Services when the employer must provide benefits or when that person has been compensated by the employer.

X

Y

Z

CHIROPRACTIC CARE EXCLUSIONS AND LIMITATIONS

The following is a list Exclusions and Limitations under Chiropractic Care benefits:

1. Any services or treatments that are furnished before the date the Enrollee becomes Eligible, or after the date the Enrollee ceases to be Eligible under the Plan, are not Covered.

2. Services or treatments that are not approved by ASH Group as Medically Necessary, in accordance with ASH Group's Clinical Services Program are not Covered. This requirement does not apply to the following services or treatments: (a) a new patient exam; (b) Urgent Services; and (c) Emergency Services.

3. Any services or treatments for conditions caused by or arising out of the course of employment or covered under Workers' Compensation or similar laws are not Covered.

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

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

6. Any services provided by a person who is a Family Member are not Covered. Family Member means a person who is related to the Covered Person in any of the following ways: spouse, [domestic partner,] brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or Child (includes legally adopted, step or foster child). A Family Member also includes individuals who normally live in the Covered Person's household.

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

8. Chiropractic Services determined to be Experimental or Investigational; procedures or services in the research stage as determined by ASH or the Plan.

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

10. Hypnotherapy, Behavior Training, Sleep Therapy, and Weight Programs.

11. Thermography.

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

13. Services or treatments for pre-employment physicals or Vocational Rehabilitation.

14. Services or treatments caused by or arising out of the course of employment or covered under Public Liability Insurance.

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

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

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

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

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

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

21. Any service that is not permitted by State Law with respect to the practitioner's Scope of Practice.

22. Treatment for conditions of the body not Covered by the Plan's benefit and not allowed by the applicable Chiropractic Scope of Practice.

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

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

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

OUTPATIENT PRESCRIPTION DRUG EXCUSIONS AND LIMITATIONS

Outpatient Prescription Drugs

- Outpatient prescription drugs are not Covered Services.
- Over-the-counter medications are not Covered Services.

Outpatient Prescription Drugs

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

Limitations And Other Coverage Terms.

1. You or Your means the Subscriber and each family member who is a Covered Person under the Plan.

2. Copayment and Coinsurance are out-of-pocket amounts You pay directly to the pharmacy provider for a Covered prescription drug. A Copayment is a flat dollar amount. Coinsurance is a percentage of The Plan'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 Plan 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 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."
10. At its sole discretion Sentara's Pharmacy and Therapeutics Committee determines which Tier a Covered drug is placed in or if a particular drug is included on the Plan's formulary. The Plan's Pharmacy and Therapeutics Committee is composed of physicians and pharmacists. The committee looks at the medical literature and then evaluates whether to add or remove a drug from the preferred/standard drug list or Your Plan's formulary. Efficacy, safety, cost, and overall disease cost are factors that are taken into consideration. The Pharmacy and Therapeutics Committee may establish monthly quantity Limits for selected medications.
11. [Intrauterine devices (IUDs), and cervical caps and their insertion are Covered under the Plan's medical benefits.]
12. Covered Food and Drug Administration (FDA) approved tobacco cessation medications (including both prescription and over-the-counter medications) are Limited to 90-day courses of treatment per year when prescribed by a health care provider.

Prescription Drug Coverage Exclusions

The following is a list of Exclusions that apply to the Plan's Prescription Drug Benefits.

1. Medications that do not meet the Plan's criteria for Medical Necessity are excluded from Coverage.
2. Medications without FDA approved indications are excluded from Coverage.
3. Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law) are excluded from Coverage except for injectable insulin. This Exclusion does not apply to over-the-counter drugs that we must Cover under federal law when recommended by the U.S. Preventive Services Task Force or other requirements under the Affordable Care Act (ACA) and prescribed by a physician.
4. Compound drugs are excluded from Coverage unless there is at least one ingredient that requires a prescription, and the drug is not essentially a copy of a commercially available drug product. All compounded prescription drugs require Pre-Authorization.
5. Non-durable disposable medical supplies and items such as bandages, cotton swabs, hypodermic needles, and durable medical equipment not listed as Covered are excluded from Coverage.
6. Immunization agents, other than those Covered by the formulary, biological sera, blood, or Blood Products are excluded from Coverage.
7. Injectables (other than those self-administered and insulin) are excluded from Coverage.
8. Medication taken or administered to the Member in the Physician's office is excluded from Coverage. This includes samples given by a Medical Provider
9. Medication taken or administered in whole or in part, while an inpatient 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 use are excluded from Coverage.
13. Drug charges exceeding the cost for the same drug in 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. Cosmetic health and beauty aids are excluded from Coverage
16. Drugs purchased from Non-Plan Providers over the internet are excluded from Coverage
17. Drugs purchased through a foreign pharmacy are excluded from Coverage unless approved by the Plan for an emergency while traveling out of the country
18. 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 Summary Plan Description.
19. 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.
20. Pharmaceuticals approved by the FDA as a medical device are excluded from Coverage, unless authorized by the Plan.

21. Drugs used to inhibit and/or suppress drowsiness, sleepiness, tiredness, or exhaustion, unless authorized by the Plan.
22. 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.
23. Raw powders or chemical ingredients are excluded from Coverage unless approved by the Plan or submitted as part of a compounded prescription
24. Sexual dysfunction drugs are excluded from Coverage.
25. Travel-related medications, including preventive medication for the purpose of travel to other countries, are excluded from Coverage.
26. Infertility drugs are excluded from Coverage.
27. Prescription or over-the-counter appetite suppressants and any other prescription or over-the-counter medication for weight loss are excluded from Coverage.
28. [Abortifacient drugs that cause abortions are not Covered.]
29. Digital Therapeutics, including digital devices, software and applications are excluded from Coverage.

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.

Sentara Health Plans

Availability of Language Assistance Services and Auxiliary Aids and Services

Amharic:
ትኩረት፡- አማርኛ የሚናገሩ ከሆነ፣ የነጻ ቋንቋ ድጋፍ አገልግሎቶች ይኖሩዎታል። መረጃን በተደራሽ ቅረጸዎች ለማቅረብ አግባብ የሆኑ ተስማሚ ረዳት እና አገልግሎቶች በነጻ ይገኛሉ። በ 1-855-687-6260 (TTY: 711) ይደውሉ ወይም አቅራቢዎን ያነጋግሩ።

Arabic:
تنبيه: إذا كنت تتحدث اللغة العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر خدمات ومساعدات إضافية مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على 1-855-687-6260 (الهاتف النصي: 711) أو تحدث إلى مقدم الخدمة الخاص بك."

Bengali/Bangla:
বিঃদ্রঃ আপনি যদি বাংলা ভাষায় কথা বলেন, তবে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবা উপলব্ধ। তথ্য সহজে বোঝার উপযোগী ফরম্যাটে দেওয়ার জন্য প্রয়োজনীয় সহায়ক উপকরণ এবং পরিষেবাও বিনামূল্যে প্রদান করা হয়। কল করুন 1-855-687-6260 (TTY: 711)-তে অথবা আপনার পরিষেবা প্রদানকারীর সঙ্গে কথা বলুন।"

Chinese (Mandarin):
注意：如果您说普通话，我们可为您提供免费的语言协助服务。我们还免费提供适当的辅助工具和服务，确保您可以无障碍获取信息。请拨打 1-855-687-6260（文本电话服务：711），或与您的服务提供商联系。

French:
ATTENTION : Si vous parlez français, des services d'assistance linguistique gratuits sont mis à votre disposition. Des aides et des services auxiliaires appropriés destinés à fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-855-687-6260 (TTY : 711) ou adressez-vous à votre prestataire. »

French Creole/Haitian Creole:
ATANSYON: Si w pale kreyòl Ayisyen, ou gen sèvis asistans lengwistik gratis ki disponib pou ou. Gen èd ak sèvis oksilyè apwopriye pou bay enfòmasyon nan fòma aksesib ki disponib gratis egalman. Rele 1-855-687-6260 (TTY: 711) oubyen pale ak founisè swen sante w la.

German:
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Unterstützungsdienste in Ihrer Sprache zur Verfügung. Entsprechende zusätzliche Hilfsmittel und Dienste, um Informationen in zugänglichen Formaten bereitzustellen, sind ebenfalls kostenlos verfügbar. Rufen Sie uns an unter 1-855-687-6260 (TTY: 711) oder sprechen Sie mit Ihrem Anbieter."

Gujarati:
ધ્યાન આપો: જો તમે ગુજરાતી બોલો છો, તો તમને મફત ભાષા સહાય સેવાઓ ઉપલબ્ધ કરાવવામાં છે. સુલભ ફોર્મેટમાં માહિતી પૂરી પાડવા માટે યોગ્ય સહાયક સહાય અને સેવાઓ પણ મફતમાં ઉપલબ્ધ કરાવવામાં આવે છે. 1-855-687-6260 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો."

Hindi:
ध्यान दें: यदि आप हिन्दी बोलते हैं तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध हैं। सुलभ प्रारूप में सूचना उपलब्ध कराने के लिए उपयुक्त सहायक साधन और सेवाएं भी निःशुल्क उपलब्ध हैं। 1-855-687-6260 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।"

Hmong:
LUS TSEEM CEEB: Yog koj hais lus Hmoob, yuav muaj cov kev pab los muab kev pab txhais lus dawb rau koj. Tsis tas li ntawd, kuj tseem muaj cov kev pab thiab cov kev pab cuam uas tsim nyog los muab cov ntaub ntawv ua cov qauv nkag siv tau pub dawb thiab. Hu rau 1-855-687-6260 (TTY: 711) los sis tham nrog koj tus kws kho mob.

Igbo:
GEE NTỊ: Ọ bụrụ na ị na-asụ asụsụ Igbo, e nwere ọrụ enyemaka asụsụ n'efu dị maka gị. Ngwaọrụ na ọrụ enyemaka kwekọrọ ekwekọ iji nye ozi n'ụdị ndị mmadụ nwere ike iji rụọ ọrụ dịkwa n'efu. Kpọọ 1-855-687-6260 (TTY:711) ma ọ bụ kwuoro onye na-enye gị ọrụ."

Italian:
ATTENZIONE: Se parla italiano, sono per Lei disponibili servizi di assistenza linguistica gratuiti. Sono, inoltre, disponibili gratuitamente strumenti e servizi ausiliari appropriati per fornire informazioni in formati accessibili. Chiami il numero 1-855-687-6260 (TTY: 711) o consulti il Suo fornitore".

Japanese:
ご注意：日本語を話される場合、無料の言語支援サービスをご利用いただけます。接近可能な形式の情報を提供するための適切な補助器具やサービスも無料でご利用いただけます。1-855-687-6260（テキスト電話（TTY）: 711）番までお電話いただくか、ご担当のプロバイダーにお問い合わせください。

Korean:
중요 안내: 한국어를 구사할 시 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하기 위한 적절한 보조 수단 및 서비스도 무료로 제공됩니다. 1-855-687-6260 번(중계 통화: 711)으로 전화하거나 제공자에게 알리십시오."

Kru/Bassa:
DYÉĐÉ-GBO-DÈ-ĐÈ: Ɔ jǔ ké m̀ dyi Ɓǎsɔ́ɔ̀-wùɖù po-nyɔ̀ jǔìn, wuɖu-xwíníín-mú-zà-zà ɓě se wíɖí péè-péè ɖò kɔ̃ɛ nì ɓó m̀ bìì. Hwòɖǒ-fɔ́nɔ́-nyɔ́ kè nyɔ-bɔ̃ǔn-po-kà ɓě ɓé nyuɛɛ se wíɖí péè-péè ɖò kɔ̃. 1-855-687-6260 (TTY: 711) Ɔ ɖà mɔ̀ɔ̀ wùɖù gbo nyɔ-kpò nyí."

Laotian:
ຄວນເອົາໃຈໃສ່: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ມີບໍລິການຊ່ວຍເຫຼືອທາງດ້ານພາສາຟຣີໃຫ້ກັບທ່ານ. ນອກຈາກນີ້ຍັງມີບໍລິການຊ່ວຍເຫຼືອເພີ່ມຕື່ມທີ່ເໝາະສົມໃນການໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ເຂົ້າເຖິງໄດ້ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ໂທ 1-855-687-6260 (TTY: 711) ຫຼື ເວົ້າກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

Mon-Khmer, Cambodian:
ការយកចិត្តទុកដាក់៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ
សេវាកម្មជំនួយភាសាគឺមានសម្រាប់អ្នកដោយឥតគិតថ្លៃ។ ជំនួយ
និងសេវាកម្មជំនួយសមស្របដើម្បីផ្តល់ព័ត៌មានក្នុងទម្រង់ដែលអាចចូលប្រើបានក៏មានដោយឥតគិត
ថ្លៃផងដែរ។ សូមទូរស័ព្ទទៅលេខ 1-855-687-6260 (ទូរលេខ: 711)
ឬទាក់ទងទៅកាន់អ្នកផ្តល់សេវាកម្មរបស់អ្នក។

Pennsylvania Dutch:
Uffbassa: Wann du Pennsylvaanisch Deitsch schwetzscht, sinn Hilf mit die Schprooch fer nix zu hawe. Aagmässiche Hilfsmittel un Hilfsdienscht fer Auskunft in e leichter verstaendlicher Gstalt sinn aach fer nix zu hawe. Ruf 1-855-687-6260 (TTY: 711) odder schwetz mit dei Versorger

Navajo:
NÁÁNÍZIN: Diné bizaad yiníł't'éego, t'áá jíík'eh saad bee áká anilyeedígíí t'áá hadoohkáát nihá. T'áá jíík'ehgo bee áká anídaaltsoozígíí át'égo bee haz'áni dóó áká aná'álwo'ígíí t'áá jíík'ehgo doo biniiyé łahgo ájíltsooz doo. Jooba' 1-855-687-6260 (TTY: 711) doo nihá bee áłchíní nínízingo bína'nitinígíí bich'į' ákót'é.

Persian/Farsi:

توجه: اگر فارسی صحبت می‌کنید، خدمات کمک زبانی رایگان برای شما موجود است. کمک‌ها و خدمات کمکی مناسب برای ارائه اطلاعات در قالب‌های قابل‌دسترس نیز به صورت رایگان موجود است. با شماره 1-855-687-6260 (TTY: 711) تماس بگیرید یا با ارائه‌دهنده خود صحبت کنید."

Polish:
UWAGA: Jeśli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Odpowiednie pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-855-687-6260 (TTY: 711) lub porozmawiaj ze swoim dostawcą."

Portuguese:
ATENÇÃO: Se você fala português, estão disponíveis serviços gratuitos de assistência linguística. Auxílios e serviços apropriados para fornecer informações em formatos acessíveis também são oferecidos sem custo. Ligue para 1-855-687-6260 (TTY: 711) ou fale com seu prestador."

Russian:
ВНИМАНИЕ! Если вы говорите по-русски, вам доступны бесплатные услуги языковой поддержки. Также бесплатно предоставляются необходимые вспомогательные средства и услуги для получения информации в доступных форматах. Позвоните по номеру 1-855-687-6260 (TTY: 711) или обратитесь к своему поставщику услуг.

Spanish:
ATENCIÓN: Si habla en español, se encuentran disponibles servicios gratuitos de asistencia lingüística para usted. También hay disponibles servicios y ayudas auxiliares adecuados para brindar información en formatos accesibles sin cargo. Llame al 1-855-687-6260 (TTY: 711) o hable con su proveedor.

Tagalog:
PAUNAWA: Kung nagsasalita ka ng Tagalog, may available na libreng serbisyo ng tulong sa wika para sa iyo. Available din nang libre ang mga angkop na pantulong na kagamitan at serbisyo para magbigay ng impormasyon sa mga accessible na format. Tumawag sa 1-855-687-6260 (TTY: 711) o kausapin ang iyong provider."

Thai:
หมายเหตุ: หากคุณพูดภาษาไทย เรามีบริการช่วยเหลือด้านภาษาให้กับคุณฟรี
มีความช่วยเหลือและบริการที่เหมาะสมเพื่อให้ได้รับข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่มีค่าใช้จ่าย โทร 1-855-687-6260 (TTY: 711) หรือสอบถามเพิ่มเติมกับผู้ให้บริการของคุณ"

Urdu:

توجہ فرمائیے: اگر آپ اردو بولتے ہیں تو آپ کے لیے مفت زبان میں مدد فراہم کی جا سکتی ہے۔ معلومات کو قابلِ رسائی شکل میں فراہم کرنے کے لیے موزوں معاون سہولیات اور خدمات بھی بلا معاوضہ دستیاب ہیں۔ 1-855-687-6260 پر کال کریں (TTY: 711) یا اپنے فراہم کنندہ سے بات کریں۔"

Vietnamese:
CHÚ Ý: Nếu quý vị nói Tiếng Việt, dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn dành cho quý vị. Chúng tôi cũng cung cấp miễn phí các phương tiện và dịch vụ hỗ trợ phù hợp nhằm cung cấp thông tin bằng các định dạng dễ tiếp cận. Hãy gọi 1-855-687-6260 (TTY: 711) hoặc trò chuyện với nhà cung cấp dịch vụ của quý vị.

Yoruba:
ÀKÍYÈSÍ: Ti o bá ń sọ èdè Yorùbá, iṣẹ́ ìrànlọ́wọ́ èdè wà fún ọ lọ́fẹ̀ẹ́. Àwọn irin iṣẹ́ àti iṣẹ́ ìrànlọ́wọ́ tí ó yẹ láti pèsè àlàyé ní àwọn ọ̀nà tí ọwọ́ ká wà ní àrọ́wọ́tó lọ́fẹ̀ẹ́ bákan náà. Pe 1-855-687-6260 (TTY: 711) tàbí kí o bá olùpèsè rẹ sọ̀rọ̀."