

EXCLUSIONS AND LIMITATIONS

Individual Product

On Exchange

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

Underwritten by Sentara Health Plans

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This document lists services that are not covered. Services mean both medical and behavioral health (mental health) services and supplies unless We specifically tell You otherwise. We do not Cover any services that are not listed in the 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

Abortions for which public funding is prohibited including voluntary, elective abortions and any related services, drugs, or supplies are excluded from Coverage. Therapeutic abortion services, drugs and supplies recommended by a Provider are Covered Services only in the following circumstances:

- When the life of the mother is endangered by a physical disorder, physical Illness, or physical Injury, including a life-endangering physical condition caused by or arising from the pregnancy itself, or
- When the pregnancy is the result of an alleged act of rape or incest.

This exclusion does not apply to any drugs, items or services covered under the Plan's preventive Care benefits.

Acts of War, Disasters, or Nuclear Accidents -In the event of a major disaster, epidemic, war, orother event beyond our control, We will make a good faith effort to give You Covered Services. However, benefits may not be able to be provided or may be delayed in the event of a major disaster. The Plan will not be responsible for any delay or failure to give services due to lack of available Facilities or staff.

Administrative Charges are not Covered including charges or costs for:

- Completion of claim or other forms;
- Receipt, transfer, or copy of medical records or reports;
- Membership, administrative, or access fees charged by Physicians or other Providers;
- Educational brochures;
- Missed appointments;
- Calls or emails to provide test results to Members, and other routine telephone calls;
- Other clerical charges.

Alternative Medicine services or treatments are not Covered including, but not limited to:

- Acupuncture;
- Holistic medicine;
- Homeopathic medicine;
- Hypnosis;
- Aroma therapy;
- Massage and massage therapy;
- Reiki therapy;
- Herbal, vitamin or dietary products or therapies;
- Naturopathy;
- Thermography;

- Orthomolecular therapy;
- Contact reflex analysis;
- Bioenergial synchronization technique (BEST);
- Iridology-study of the iris;
- Auditory integration therapy (AIT);
- Colonic irrigation.

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

Unless Covered under the Plans benefits for Habilitative Therapy and Services, Non-medical

Ancillary Services are not Covered, including;
- Vocational rehabilitation services;
- Employment counseling;

Autopsies are not a Covered Service.

B

Batteries are not Covered except for use in:
- Motorized wheelchairs;
- Left ventricular assist device (LVAD);
- Cochlear implants;
- Ventilators;
- Durable Medical Equipment;
- Hearing aids for Children age 18 and under and limited to one initial set of batteries.

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

Birthing Center Services are Covered at contracted Facilities only.
Transportation or storage of **blood** is not Covered.

Bone Densitometry Studies more than once every two years are not Covered unless Medically Necessary and We have approved the services.

Breast Augmentation (Enlargement) or Breast Mastopexy (Breast 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 exclusion does not apply to procedures required by State or Federal law for breast reconstruction and symmetry performed at the same time of a mastectomy or following mastectomy or as provided under the Plan's Reconstructive Surgery benefit.

Breast Milk from a donor is not Covered.

C

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

Complications of Non-Covered Services are not Covered. This includes care for problems directly related to a service that is not covered by the Plan. Directly related means that the care took place as a direct result of a non-Covered Service and would not have taken place without the non-Covered Service.

Cosmetic Services are not Covered. This includes treatments, services, prescription drugs, equipment, or supplies given for cosmetic services. Cosmetic services are meant to preserve, change, or improve how you look for reasons other than for Medical Necessity.

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.
- Medically Necessary benefits determined according to nondiscriminatory criteria that are consistent with current medical standards.

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

Court ordered examinations or treatments, and Temporary Detention Orders (TDOs) are not Covered unless Medically Necessary and approved by the Plan**.**

Custodial Care, Non-skilled Convalescent Care or Rest Cures, even when recommended by a professional or performed in a Facility, such as a Hospital or Skilled Nursing Facility, or at home. This exclusion does not apply to Hospice care.

D

Dentistry/Oral Surgery/Adult Dental Care

These exclusions do not apply to services that must be covered by law.

The following services are not Covered unless provided under the Plan's Oral and Maxillofacial Surgery benefit:

- 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 any 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;
- Treatment for biting or chewing injuries.

E

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

- Services or supplies for teaching, vocational, or self-training purposes, except as covered as a habilitative service under the Plan.
- Driver Education and 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;
- This exclusion does not apply to educational services Covered under the Plan’s benefit for Diabetic Insulin, Testing Supplies, Equipment, and Education, Diabetes Care Management, Lymphedema, Residential Treatment Services, Outpatient Prescription Drug Coverage, and some Preventive and Wellness Services for disease management and Reproductive Health Services. Applied Behavioral Analysis is not an educational service.
- This exclusion does not apply to educational services required by law.

Emergency Transportation/Ambulance Air ambulance will not be Covered if you are taken to a Facility that is not an acute care Hospital (such as a Skilled Nursing Facility), or if you are taken to a physician’s office or your home. Coverage is not available for air ambulance transfers for the reason of being treated in a specific hospital or by a specific physician.

Examinations, required for employment, insurance, or judicial or administrative proceedings are not Covered, unless Covered under the Plan’s Preventive Care benefits or Medically Necessary.

Experimental or Investigational services or supplies that the Plan determines are Experimental/Investigational are not Covered. This exclusion also applies to services related to Experimental/Investigational services, whether you get them before, during or after you get the Experimental/Investigational service or supply. The fact that a service or supply is the only available treatment will not make it a Covered Service.

Please read the Experimental/Investigational definition in the “Definitions” section for the criteria used in deciding whether a service is experimental or investigative.

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.

Foot Care Services and treatment are not Covered including:

- Cleaning and preventive foot care, including but not limited to: Cleaning and soaking the feet, applying skin creams to care for skin tone, and other services that are given when there is not an illness, injury or symptom involving the foot;
- Flat foot conditions;
- Foot orthotics, orthopedic shoes or footwear or support items unless Medically Necessary;
- Fitting, castings and other services related to devices of the feet, unless used for an Illness affecting the lower limbs;
- Subluxations of the foot;
- Treatment or removal of corns and calluses and care of toenails unless Medically Necessary;
- Fallen arches;
- Weak feet;
- Tarsalgia;
- Metatarsalgia;
- Hyperkeratoses

Free Care is not a Covered Service. 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. If Worker's Compensation benefits are not available to You, this exclusion does not apply if services are considered Medically Necessary Covered Services under the Plan.

G

H

Hearing Aids and related services for Members over age 18 are not Covered including:

- Examinations for fitting and molds;
- Hearing aid batteries except for cochlear implants;
- Other hearing aid supplies or repair services.

This exclusion does not apply to cochlear implants

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 unless it is part of Covered hospice care. We do not Cover homemaker services, food and home delivered meals. Services given 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.

Hospital Services listed below are not Covered Services:

- Guest Meals;
- Telephones, televisions, and other convenience items;
- Private rooms unless it is Medically Necessary that You use a private room for isolation and no isolation Facilities are available.

Hypnotherapy is not Covered.

I

Immunizations required for foreign travel or for employment are not Covered unless Covered under Preventive Care Services.

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

Infertility Services listed below are not Covered Services: Please see Infertility Services under section [6] "What is Covered."

- Services, tests, medications, and treatments for the diagnosis or treatment of Infertility not listed as Covered;
- Services, tests, medications, and treatments for the enhancement of conception;
- In-vitro Fertilization programs;
- Artificial insemination or any other types of artificial or surgical means of conception;
- Drugs administered in connection with Infertility procedures;
- GIFT (Gamete Intrafallopian Transfer) programs;
- ZIFT (Zygote Intrafallopian Transfer) programs;
- Reproductive material storage;
- 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 Covered**.**

M

Medical Equipment, Exercise equipment, Devices and Supplies that are disposable, available over the counter without a prescription from a practitioner, or for convenience are not Covered including:

- Adaptations to Your home, car, van, other vehicle or office;
- Bicycles, treadmills, stair climbers, and other exercise equipment;
- Free weights, exercise videos and other training equipment;
- Air conditioners, purifiers, humidifiers and dehumidifiers;
- Whirlpool baths;
- Hypoallergenic pillows or bed linens;
- Under pads and diapers;
- Telephones;
- Televisions;
- Handrails, ramps, elevators, escalators, and stair glides;
- Orthotics not approved by the Plan;

- Water filters or purification devices;
- Disposable diapers;
- Over the counter supplies, such as bandages, tape, gauze pads, alcohol, iodine, 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 instructors;
- Ice bags;
- Chairs or recliners;
- Other personal comfort or over the counter hygienic items.

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

N

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 except when Medically Necessary. Pre-Authorization is required.

Services or treatment You receive from **Out-of-Network Non-Plan Providers** will not be Covered 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 services will be Covered under the Plan's In-Network benefits. Members are responsible for the In-Network cost sharing credited toward In-Network Deductibles and Maximum Out-of-Pocket Amounts;
- Emergency Services received from Out-of-Network non-Plan Facilities and Providers will be Covered under the Plan's In-Network benefits. Members are responsible for In-Network cost sharing credited toward In-Network Deductibles and Maximum Out-of-Pocket Amounts;
- Or if authorized by the Plan.

P

PARS System (Physical Activity Reward System) is not a Covered Service unless Medically Necessary and approved by the Plan.

PASS Devices (Patient Activated Serial Stretch) are not Covered Services unless Medically Necessary and approved by the Plan.

Paternity Testing is not Covered.

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

Penile implants are not Covered.

Physician Examinations <u>are limited as follows:</u>

- Physicals for employment, insurance or recreational activities are not Covered Services except if benefits are received under Preventive and Wellness Services.
- Executive physicals are not Covered Services except if benefits are received under Preventive and Wellness Services.
- Second opinion from a Non-Plan Provider is Covered only when authorized by the Plan.
- Services or supplies ordered or done by a Provider not licensed to do so are not Covered Services.

Private Duty Nursing in an Inpatient setting is not Covered.

Prosthetics for sports or cosmetic purposes are not Covered.

Non-Covered **Providers,** such as massage therapists and physical therapist technicians and the services they provide are not Covered unless We have approved the services.

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Services – <u>We do not Cover any of the services or charges listed below.</u>

- Services deemed **not Medically Necessary**;
- Services prescribed, ordered, referred by or given by an immediate family member;
- Services provided before Your Plan effective date;
- Services provided after Your Coverage ends;
- Services after a benefit limit has been reached;
- Services or supplies that are a direct result of a non-Covered service.

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

Skilled Nursing Facility (SNF) Stays are not Covered when the Skilled Nursing Facility is used mainly for care of the aged, custodial or domiciliary care; or mainly for a place of rest, educational, or similar services; a private room is not Covered unless Medically Necessary. This exclusion does not apply to Covered Services under the Plan's benefits for Skilled Nursing Facility Services and Hospice Care.

T

Temporomandibular Joint Treatment fixed appliances or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures) are not Covered Services unless for treatment Covered under the Plan's Temporomandibular Joint (TMJ) Diagnostic and Surgical Procedures benefit and appliances must be approved by Us.

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

Physical, Speech, and Occupational **Therapies** are limited as stated on Your Schedule of Benefits. Visit limits do not apply to chiropractic, osteopathic, manipulation therapy services or outpatient habilitative or rehabilitative therapy services if You get that care as part of the Hospice or Early Intervention benefit, or as part of a treatment plan for Autism Spectrum Disorder. Visit limits do not apply to outpatient or home health habilitative or rehabilitative therapy services for mental health conditions or substance use disorders.

Unless otherwise listed as a Covered Service the following will not be Covered:

- Lessons for sign language;
- Therapies available in a school program;
- Therapies available through state and local funding;
- Nature therapies;
- Recreational therapies such as hobbies, arts, and crafts unless provided under a program of treatment in a licensed Residential Treatment Facility;
- Exercise or equine therapies;
- Driver evaluations as part of occupational therapy;
- Functional capacity testing needed to return to work;
- Work hardening programs.

Total Body Photography is not a Covered Service.

Transplant Services - <u>We do not Cover any of the following</u>:

- Organ and tissue transplant services not listed as Covered;
- Organ and tissue transplants not Medically Necessary;
- Organ and tissue transplants considered Experimental or Investigative;
- Services from non-contracted Providers unless Pre-Authorized by the Plan;
- Travel and lodging services not approved by the Plan including mileage, rental cars, airfare, standard hotel accommodations, companion accommodations;
- Travel and lodging services including childcare, meals, taxis, buses, tolls, lodging upgrades;
- Services not listed as Covered under the Plan's Transplant Services benefit;
- 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 Covered individual is donating an organ to a non-Covered member.

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.

Transportation services that are not Emergency Services are only Covered when approved and authorized by the Plan.

Travel outside of the United States of America: Treatment and services other than Emergency Services are not Covered Services.

U

V

Treatment of **Varicose Veins** or **Telangiectatic Dermal Veins** (spider veins) are not Covered Services when considered by the Plan to be for cosmetic reasons.

Video Recording or Video Taping of any service or procedure is not Covered except when necessary to provide Covered Services under the Plan's benefit for -106 Services.

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

The following **Vision Services or Materials** are not Covered:

- Corrective or protective eyewear required for work;
- Eye exercise training;
- Eye Movement Desensitization and Reprocessing Therapy is not Covered unless Medically Necessary;
- Eye Corrective Surgery such as Radial Keratotomy, Photorefractive Keratectomy (PRK), or Laser-Assisted In Situ Keratomileusis (LASIK).

W

Weight Loss Surgery and Programs are not Covered Services including:

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

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

Extraction of erupted or impacted **Wisdom Teeth** are not Covered except when Medically Necessary to prepare the mouth for other Covered medical services and treatments.

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 are excluded from Coverage. However, the Plan may approve Coverage of limited quantities of an OTC under the Plan's Preventive Care benefits or under the Plan's exception process. You must have a Physician's prescription for the drug, and the drug must be included in the Plan's list of Covered Preferred or Standard drugs. This limitation does not apply to injectable insulin. This limitation does not apply to Covered contraceptive drugs and devices including those available over-the-counter with or without a prescription.
3. Unless required by law, certain Prescription Drugs may not be Covered or may be subject to step therapy protocols and exception requests 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. Please see Step Therapy Protocols and Exception Requests section in this Evidence of Coverage for more information.
4. Our formulary is a list of FDA-approved medications that We Cover. At its sole discretion, the Plan's 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. The Plan does not apply any annual or Plan year dollar limits or other benefit maximums to
   Physician prescribed diabetic supplies Covered under the Plan's prescription drug benefit or the Plan's medical benefits.
6. Intrauterine devices (IUDs), implants, and cervical caps and their insertion are Covered under the Plan's medical benefits.
7. Covered 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.

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. You have the right to file an appeal. Please see Section 10 on filing an internal or external appeal.
2. Medications with no approved FDA 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 the Plan 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 when prescribed by a Physician. This exclusion does not apply to Covered contraceptive drugs and devices including those available over-the-counter with or without a prescription.
4. Compounded 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.
5. Non-durable disposable medical supplies and items such as bandages, cotton swabs, hypodermic needles, and durable medical equipment not listed as a Covered benefit under the Plan's Durable Medical Equipment (DME) and Medical Devices, Orthotics and Prosthetics, and Medical and Surgical Supplies in Section 6 "What is Covered" of the Evidence of Coverage are excluded from Coverage.
6. Immunization agents, biological sera, blood, or blood products are excluded from Coverage unless Covered under the Plan's Hospital Services, Hemophilia and Congenital Bleeding Disorders, Infusion Services, Medications Administered by a Medical Provider, Surgery and Preventive and Wellness Services benefits of the Evidence of Coverage or are determined to be Medically Necessary and clinically appropriate for a Covered condition.
7. Injectables (other than those self-administered and insulin) are excluded from Coverage, unless authorized by the Plan. Office-based injectables administered by a Provider are Covered under the Plan's medical benefits.
8. Medication taken by, or administered to, the Member in a Physician's office is excluded from Coverage unless Covered under the Plan's "Medication Administered by a medical Provider" benefits section in this Evidence of Coverage (Section 6 "What is Covered".) This includes samples given by a Medical Provider.
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 to be experimental 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. Over-the-Counter Items, Drugs, devices and products, or prescription legend drugs with over-the-counter equivalents and any drugs, devices or products that are therapeutically comparable to an over-the-counter drug, device, or product are excluded from Coverage. This includes prescription legend drugs when any version or strength becomes available over the counter. This Exclusion does not apply to over-the-counter products required under federal law with a Prescription. This exclusion does not apply to Covered contraceptive drugs and devices including those available over-the-counter with or without a prescription.
14. Cosmetic health and beauty aids are excluded from Coverage.
15. Drugs purchased from Non-Plan Providers are excluded from Coverage.

16. Drugs purchased through a foreign pharmacy are excluded from Coverage unless approved by the Plan for an emergency while traveling out of the country.
17. Minerals, topical and oral fluoride treatments, 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.
18. Pharmaceuticals approved by the FDA as a medical device are excluded from Coverage unless Covered under the Plan's Durable Medical Equipment (DME) and Medical Devices, Orthotics, and Prosthetics, and Medical and Surgical Supplies benefits in Section 6 "What is Covered" of Your Evidence of Coverage.
19. Raw powders or chemical ingredients are excluded from Coverage unless approved by the Plan or submitted as part of a compounded prescription.
20. Sexual dysfunction drugs to treat sexual or erectile problems are excluded from Coverage.
21. Travel related medications, including preventive medication for the purpose of travel to other countries are excluded from Coverage.
22. Infertility drugs are excluded from Coverage.
23. Prescription or over the counter appetite suppressants and any other prescription or over the counter medication mainly used for weight loss are excluded from Coverage.
24. Digital Therapeutics, including digital devices, software, and applications are excluded from Coverage unless Medically Necessary.
25. **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.
26. 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.
27. Refills one year after date of original prescription are excluded from Coverage.
28. Administration charges for the administration of any drug except for approved Covered immunizations are excluded from Coverage.
29. Delivery Charges for delivery of prescription drugs 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 Plan's pharmacy authorization department. After reasonable investigation and consultation with the prescribing physician, We will make a determination. We 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 on by the Plan.

CHIROPRACTIC CARE LIMITATIONS AND EXCLUSIONS

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

1. Any services or treatments that are furnished before the date the Member becomes eligible, or after the date the Member ceases to be eligible under the Member's Plan are not Covered.

2. Services or treatments that are not 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 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 an immediate family member are not Covered. Immediate 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).
7. Chiropractic services determined to be Experimental or Investigational; procedures or services in the research stage as determined by ASH or the Plan.
8. Chiropractic services not listed as a Covered Service under the Plan.
9. Thermography.
10. Education programs, non-medical lifestyle or self-help, or any self-help physical exercise training.
11. Therapeutic mattresses, supplies, or any other similar devices or appliances.
12. 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.
13. Services which do not require the supervision of or performance by a licensed Chiropractor.
14. Transportation costs to or from appointment(s).
15. Any service that is not permitted by state law with respect to the practitioner's scope of practice.
16. Treatment for conditions of the body not Covered by the Plan's benefit and not allowed by the applicable chiropractic scope of practice.
17. Any services rendered for elective or maintenance care including services provided to a Member whose treatment records indicate he or she has reached maximum therapeutic benefit, and Habilitative Services determined by ASH as not Medically Necessary.
18. Vitamins; minerals; herbs, herbals and herbal products, injectable supplements and injection services or other similar products. This exclusion does not apply to special food products or supplements Covered under the Plan's Medically Necessary Formula and Enteral Nutrition Products benefits in Section 6 "What is Covered" of Your Evidence of Coverage.
19. MRI, CT scans or other advance imaging ordered by a Doctor of Chiropractic.

PEDIATRIC VISION CARE AND SERVICES EXCLUSIONS AND LIMITATIONS

<u>The following are excluded or limited under this Pediatric Vision Services Benefit:</u>

1. Orthoptic or vision training, subnormal vision aids and any associated supplemental testing are not Covered, except when Medically Necessary.
2. Aniseikonic lenses are not Covered.

3. Medical and/or surgical treatment of the eye, eyes or supporting structures are Covered under the Plan's Medical Benefit.
4. Safety eyewear is not Covered.
5. Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof is not Covered.
6. Plano (non-prescription) lenses and/or contact lenses are not Covered.
7. Non-prescription sunglasses are not Covered.
8. Two pair of glasses in lieu of bifocals are not Covered.
9. Services rendered after the date an Insured Person ceases to be Covered under the Policy are not Covered, except when Vision Materials ordered before Coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order.
10. Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next benefit frequency when vision materials would next become available.

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."