Sentara®
Health Plans

EXCLUSIONS AND LIMITATIONS

Sentara Health Plans

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 chapter lists services that are not Covered. Services mean both medical and behavioral health (mental health) services and supplies unless We specifically tell You otherwise. We do not cover any services that are not listed in the Covered Services section unless required to be Covered under state or federal laws and regulations. We do not cover any services that are not Medically Necessary. We sometimes give examples of specific services that are not Covered but that does not mean that other similar services are Covered. Some services are Covered only if We authorize them. When We say You or Your We mean You and any of Your family members Covered under the Plan. Call Member Services if You have questions.

A

Abortion, including abortifacient drugs, is a Covered Service 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.

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

Administrative Charges are not Covered including charges or costs for:

- Completion of claim or other forms;
- Transfer or copy of medical records or reports;
- Access or concierge fees;
- Missed appointments;
- Routine telephone calls;
- Other clerical charges.

Alternative Medicine services or treatments are not Covered including:

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

- Colonic irrigation.

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

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

Autopsies are not a Covered Service.

B

Batteries are not a Covered except for use in:
- Motorized wheelchairs;
- Left ventricular assist device (LVAD);
- Cochlear implants;
- Ventilators;
- 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 Services unless We approve the services.

Birthing Center Services are Covered Services at contracted Facilities only.

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

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

Bone Densitometry Studies more than once every two years are not Covered unless Medically Necessary.

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 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.

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

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

- Services to preserve, change or improve how a person looks;
- Services to change the texture or look of skin, the size, shape or look of facial or body features;
- Surgery, reconstructive surgery, or other procedures that are cosmetic not Medically Necessary to restore function or alleviate symptoms which can effectively be treated non-surgically;
- Any service or supply that is a direct result of a non-Covered service;
- Non-medically necessary treatment or services resulting from complications due to cosmetic 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;
- **Cosmetic skin condition** treatments by laser, light or other methods unless Medically Necessary.

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

Court ordered examinations or treatments and Temporary Detention Orders (TDOs) are not Covered unless they are determined to be Medically Necessary and are a Covered Service under the Plan.

Custodial Care, Non-skilled Convalescent Care or Rest Cures, 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

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.

E

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

- Self-training services;
- Vocational training;
- Tutorial services or testing required to complete Educational, degree or residency requirements;
- Testing or screening services for classroom performance except when services qualify as Early Intervention Services;
- This exclusion does not apply to educational Services Covered under the Plan's benefit for Lymphedema, Residential Treatment Services, Outpatient Prescription Drug Coverage, Diabetic Insulin, Testing Supplies, Equipment, and Education for Diabetes Care Management and some Preventive and Wellness Services for disease management.

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

Experimental or Investigative drugs, devices, treatments, or services are not Covered Services. This does not apply to Covered Services for Clinical Trials. **Experimental or Investigative means any of the following situations:**

- The majority of the medical community does not support the use of this drug, device, medical treatment or procedure; or
- The use of this drug, device, medical treatment or procedure may have been shown to be unsafe and/or of no or questionable value as reported by current scientific literature and/or regulatory agencies; or
- The research regarding this drug, device, medical treatment or procedure may be so limited that an evaluation of safety and efficacy cannot be made; or
- The drug or device is not 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, or medical treatment.
- Drugs for certain clinical trials are not Covered Services. This includes drugs paid for directly by the clinical trial or another payor.

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.

Palliative or cosmetic **Foot Care Services** are not Covered including:

- Cleaning and preventive foot care when there is no Illness or Injury to the foot;
- Flat foot conditions;
- Foot orthotics, orthopedic and corrective shoes not part of a leg brace;
- Fitting, castings and other services related to devices of the feet, unless used for an Illness affecting the lower limbs;
- Subluxations of the foot;
- Treatment or removal of corns and calluses and care of toenails 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

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 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.

Home Health Care Skilled Services are not Covered Services unless Medically Necessary and We have approved the services. Services and visits are limited as stated on Your Scheduled 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.

Hospital Services listed below are not Covered Services:

- Guest Meals;
- Telephones, televisions, and other convenience items;
- Private inpatient Hospital rooms unless You need a private room because You have a highly contagious condition or are at greater risk of contracting an infectious disease because of Your medical condition;

Hypnotherapy is not Covered.

I

Immunizations required for foreign travel or for employment are not Covered unless 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:

- 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);
- ZIFT 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

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

Medical Equipment, Exercise equipment, Devices and Supplies that are disposable, available over the counter, or for convenience are not Covered including:

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

Newborns or other Children of a Covered Dependent Child are not Covered unless the grandparent Subscriber or spouse are the legal guardian or adoptive parent of that grandchild. This exclusion does not apply to Coverage of Hospital services for routine newborn and nursery care for the newborn during mother's normal hospital stay.

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 for treatment of convergence insufficiency. 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.

PASS Devices (Patient Activated Serial Stretch) are not Covered Services unless Medically Necessary.

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

Q

R

Reconstructive surgery is not a Covered Service unless the surgery follows a trauma which causes anatomic functional impairment or is needed to correct a congenital disease or anomaly which has resulted in a functional defect. Emotional conflict or distress does not constitute Medical Necessity. This exclusion does not apply to reconstructive surgery required under the Women's Health and Cancer Rights Act or Covered Services under the Plan's Reconstructive Surgery benefit.

Residential treatment center care or care in another Non-skilled settings are not Covered Services when services are merely custodial in nature.

S

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 or supplies prescribed, performed or directed by a provider not licensed to do so;
- Services provided before Your Plan effective date;
- Services provided after Your Coverage ends;
- Services after a benefit limit has been reached;
- 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 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 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.

The following are not Covered Services:

- 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 child care, mileage, rental cars;
- Services not listed as Covered under the Plan's Transplant Services;
- 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 Telemedicine Services.

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

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 use 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 treatment.

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.
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. Any Plan maximum benefit does not apply to Physician prescribed diabetic supplies Covered under the Plan's prescription drug benefit or the Plan's medical benefit.
6. Intrauterine devices (IUDs), implants, and cervical caps and their insertion are Covered under the Plan's medical benefits.

Prescription Drug Coverage Exclusions

The following is a list of exclusions that apply to Your drug benefit.

1. Medications that do not meet the Plan's criteria for Medical Necessity are excluded from Coverage. 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. 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 requires Pre-Authorization.
4. 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.

5. Immunization agents, biological sera, blood, or blood products are excluded from Coverage unless listed as a Covered Service 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.
6. Injectables (other than those self-administered and insulin) are excluded form Coverage, unless authorized by the Plan.
7. Medication taken or administered in whole or in part, while a Member is a patient in a licensed Hospital is excluded from Coverage.
8. Medications for cosmetic purposes only, including but not limited to Retin-A for aging, are excluded from Coverage.
9. Medications for experimental indications and/or dosage regimens determined by the Plan to be experimental are excluded from Coverage.
10. Therapeutic devices or appliances, including but not limited to support stockings and other Non-medical items or substances are excluded from Coverage.
11. 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.
12. Drugs with a therapeutic over-the-counter (OTC) equivalent are excluded from Coverage. However, the Plan may approve Coverage of limited quantities of an OTC drug 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.
13. Cosmetic health and beauty aids are excluded form Coverage.
14. Drugs purchased from Non-Plan Providers over the internet are excluded from Coverage.
15. Drugs purchased through a foreign pharmacy are excluded from Coverage unless approved by the Plan for an emergency while traveling out of the country.
16. 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.
17. 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.
18. Raw powders or chemical ingredients are excluded from Coverage unless approved by the Plan or submitted as part of a compounded prescription.
19. Sexual dysfunction drugs are excluded from Coverage.
20. Infertility drugs are excluded from Coverage.
21. 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.
22. Abortifacient drugs that cause abortions are not Covered.
23. **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.
24. This plan uses a Closed Formulary. Any prescription drugs, over the counter drugs, or devices that are not included on the Plan’s Prescription Drug Formulary are not Covered.

Non-formulary requests. You have the right to request a Non-formulary prescription drug if You believe that You need a prescription drug that is not on the Plan's list of Covered drugs (formulary), or You have been receiving a specific Non-formulary prescription drug for at least six months previous to the development or revision of the formulary and Your prescribing physician has determined that the formulary drug is inappropriate for Your condition or that changing drug therapy presents a significant health risk to You. Your physician must complete a medical necessity form and deliver it to the Plan's pharmacy authorization department. After reasonable investigation and consultation with the prescribing physician, 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 in by the Plan.

CHIROPRACTIC CARE LIMITATIONS AND EXCLUSIONS

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

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

The following are excluded or limited under this Pediatric Vision Services Benefit:

1. Orthoptic or vision training, subnormal vision aids and any associated supplemental testing are not Covered, except when Medically Necessary and services or visits have been authorized for treatment of convergence and insufficiency.
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. Plan (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.

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Quý vị cần được giúp đỡ bằng một ngôn ngữ khác? Hãy gọi cho chúng tôi.

Kailangan ng tulong sa ibang wika? Tawagan kami.

¿Necesita ayuda en algún otro idioma? Llámenos.

Saad łahgo át'éhígíí daa ts'í bee shíká a'doowoł nínízin. Nihich'į' hólne'.

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