# EXCLUSIONS AND LIMITATIONS

## Business*EDGE*®

## *OPTIMA* VANTAGE/POS PRODUCTS

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

Administered by Sentara Health Plans, Inc.

V2019 Vantage.SF

## EXCLUSIONS AND LIMITATIONS- Business*EDGE*® *VANTAGE PRODUCTS*

This is a list of 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 unless required to be covered under state or federal laws and regulations. The Plan does not cover services unless they are Medically Necessary. Examples may be given of specific services that are covered. However, that does not mean that other similar services are covered. Some services are covered only if they have been authorized by the Plan.

### A

**Abortion** is covered in the first 12 weeks of pregnancy. After 12 weeks abortion is covered if the mother's life is at risk, if there are major fetal abnormalities, or in the case of rape or incest.

**Acupuncture** is not covered.

**Adaptations to Your Home, Vehicle or Office** are not covered. Handrails, ramps, escalators, elevators, or any other changes because of a medical condition or disability are not covered.

**Ambulance Service** for non-emergency transportation is not covered unless authorized by the Plan.

Non-medical **Ancillary Services** You are referred to are not covered. Vocational rehabilitation services, employment counseling, relationship counseling for unmarried couples, pastoral counseling, expressive therapies, health education, or other non-medical services are not covered.

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

**Applied Behavioral Analysis (ABA)** is not covered.

**Aromatherapy** is not covered.

**Autopsies** are not covered.

### B

**Batteries** are not covered except for motorized wheelchairs and cochlear implants when authorized

**Blood Donors**. We do not cover any costs for finding blood donors. We do not cover the cost of transportation and storage of blood in or outside the Plan's Service Area.

**Bone Densitometry Studies** more than once every two years are not covered unless authorize by the Plan.

**Bone or Joint treatment of the head, neck, face or jaw**. The Plan does not exclude coverage or impose limits on bone or joint treatments of the head, neck, face, or jaw that are more restrictive than limits on treatment involving any bone or joint of the skeletal structure if the treatment is required because of a medical condition or injury which prevents normal function of the joint or bone, and is deemed Medically Necessary to attain functional capacity of the affected part. The treatment must be Medically Necessary and be required because of a medical condition or injury that prevents normal function of the joint or bone.

**Botox injections** are not covered unless the Plan has approved them.

**Breast Augmentation or Mastopexy** is not covered unless the Plan has authorized them. Cosmetic procedures or surgery for breast enlargement or reduction are not covered. Procedures for correction of cosmetic physical imperfections are not covered. Breast implants are not covered. This does not apply to procedures required by State or Federal law for breast reconstruction and symmetry following mastectomy.

**Breast Ductal Lavage** is not covered.

**Breast Milk** from a donor is not covered.

### C

**Chelation Therapy** is not covered except for arsenic, copper, iron, gold, mercury or lead poisoning.

**Contact Lenses** are not covered. Fitting of lenses or eyeglasses is not covered. The Plan will cover 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. The Plan does not cover medical, surgical, and mental health services for or related to cosmetic surgery or cosmetic procedures. Emotional conflict or distress does not cause a service or procedure to be Medically Necessary. **The Plan will not cover any of the following:**

- 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;
- Penile implants;
- Cosmetic skin condition treatments by laser, light or other methods.

**Costs of Services paid for by Another Payor** are not covered. The Plan does 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 referral procedures. The Plan will not cover the cost of services that were denied by the above insurance programs for failure to meet administrative or filing requirements.

**Court ordered examinations or treatments** are not covered unless they are determined to be Medically Necessary and are a Covered Service under the Plan

**Custodial Care** is not covered. The Plan will not cover any of the following:

- Residential care;
- Rest cures;
- Care from institutions or facilities licensed solely as residential treatment centers, intermediate care facilities, or other non-skilled sub-acute inpatient settings;
- Examination or care ordered by a court of law not authorized by the Plan to be provided at a Plan Provider.

## D

### Dentistry/Oral Surgery/Dental Care

#### Dentistry

- Restorative services and supplies necessary to treat, repair or replace sound natural teeth are not covered.
- The Plan will cover Medically Necessary dental services from an accidental injury. It does not matter when the injury occurred. For injuries occurring on or after Your effective date of coverage treatment must be sought within 60 days of the accident.
- The Plan will cover 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.
- 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 covered.
- Orthodontic treatment prior to orthognathic surgery is not covered.
- Dental implants or dentures and any preparation work for them are not covered.
- Extraction of wisdom teeth is not covered.

**Dental Care**

- Dental care, treatment, supplies, orthodontia, extractions, repositioning, X-rays, periodontal work, or any other services dental in nature are not covered.
- Dental implants or dentures and any preparation work for them are not covered.

**Diagnostic tests or Surgical Procedures** are not covered where there is insufficient scientific evidence of its safety or efficacy in improving clinical outcomes.

**Disposable Medical Supplies** are not covered 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.

**Driver Training** is not covered.

**Durable Medical Equipment (DME)** is covered up to the limits stated on Your Plan's Schedule of Benefits. The Plan will only cover an amount, supply or type of DME that will safely and adequately treat Your condition. The Plan will not cover 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. This includes drugs paid for directly by the clinical trial or another payor.

**E**

**Electron Beam Computer Tomography (EBCT)** is not covered. The Plan does not cover any other diagnostic imaging test where there is insufficient scientific evidence of its safety or efficacy in improving clinical outcomes.

Services, treatment, or testing required to complete **Educational Programs**, degree requirements, or residency requirements are not covered.

**Educational Testing, Evaluation, Screening, or tutorial services** are not covered. 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 unless they are used as the sole or major source of nutrition. The Plan does not cover over the counter supplements, over the counter infant formulas, or medical foods.

**Examinations**, testing or treatment required for employment, insurance, or judicial or administrative proceedings are not covered.

**Exercise Equipment** is not covered. The Plan does not cover bicycles, treadmills, stair climbers, free weights, exercise videos, or any other exercise equipment. The Plan does not cover pool, gym, or health club membership fees.

**Experimental or Investigative** drugs, devices, treatments, or services are not covered. 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.

**Eye Examinations** required for work are not covered. Corrective or protective eyewear required for work is not covered.

**Eye Glasses** and contact lenses are not covered. Fitting of lenses or eyeglasses is not covered. The Plan will cover 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 covered.

**Eye Corrective Surgery** such as Radial Keratotomy, PRK, LASIK, or any other eye corrective surgery is not covered.

**F**

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

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

**The Plan does not cover** any of the following **Foot Care Services** except for Members with Diabetes or severe vascular problems:

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

**G**

**Genetic Testing and Counseling** is not covered unless authorized by the Plan. Counseling is covered only as part of the approved genetic test unless considered preventive care.

**GIFT programs (Gamete Intrafallopian Transfer)** are not covered.

**Growth Hormones** are only covered under the Plan's Outpatient Prescription Drug Benefits. Growth hormones for the treatment of idiopathic short stature are not covered.

## H

**Hearing Aids** are not covered. Fittings, molds, batteries or other supplies are not covered.

**Home Births** are not covered.

**Home Health Care Skilled Services** are not covered unless You are homebound, physically unable to seek care on an outpatient basis or the service is provided in lieu of inpatient hospitalization. Services are limited as stated on Your Plan's Schedule of Benefits. The Plan does not cover any services after You have reached Your Plan's limit. The Plan will only cover services or supplies listed in Your home health care plan. Custodial care is not covered.. Transportation is not covered.

**Hypnotherapy** is not covered.

## I

**Immunizations** required for foreign travel or for employment are not covered.

**Implants** for cosmetic breast enlargement are not covered. The Plan does not cover cosmetic procedures or cosmetic surgery for breast enlargement or reduction. The Plan does not cover procedures for correction of cosmetic physical imperfections. This does not apply to procedures required by State or Federal law for breast reconstruction and symmetry following mastectomy.

**Incarceration** – The Plan does not cover services and treatments done during incarceration in a Local, State, Federal or Community Correctional Facility or prison.

**Infertility Services** are not covered. The **Plan will not cover any of the following**:

- Services, tests, medications, and treatments for the diagnosis or treatment of Infertility;
- Services, tests, medications, and treatments for the enhancement of conception;
- Services, tests, medications, and treatments that aid in or diagnose potential problems with conception;
- In-vitro Fertilization programs;
- Artificial insemination or any other types of artificial or surgical means of conception;
- Drugs administered in connection with infertility procedures;
- GIFT/ZIFT programs;
- Reproductive material storage;
- Treatment 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;
- Semen analysis;
- Sims-Huhner test (smear);
- Drugs used to treat infertility.

## J

## K

**Keloids** from body piercing or pierced ears are not covered.

## L

**For Vantage HMO Plans Laboratory Services** from Non-Plan providers or laboratories are not covered. Medically Necessary Covered Services provided by a Non-Plan Provider during an Emergency, or during an authorized Admission to a Plan Facility, will be Covered under In-Network benefits.

**For POS and Plus PPO Plans Laboratory Services** from Non-Plan providers or laboratories are covered under Out-of-Network benefits only. Medically Necessary Covered Services provided by a Non-Plan Provider during an Emergency, or during an authorized Admission to a Plan Facility, will be Covered under In-Network benefits.

## M

**Massage Therapy** is not covered unless provided as part of an approved therapy program.

**Matristem Extracellular Wound Care System** is not covered.

**Maximum Benefit Amounts** are stated on Your Plan's Schedule of Benefits. The Plan does not cover any additional benefits after a benefit limit has been reached.

**Measurement of Ocular Blood Flow by Tonometer Repetitive IOP** is not covered.

**Medically Necessary Treatments** - Any services, supplies, treatments, or procedures not specifically listed as a Covered Service, and any other services, supplies, or treatments or procedures determined not to be Medically Necessary are not covered unless required to be covered under state or federal laws and regulations.

**Medical Equipment, Devices and Supplies** that are disposable or mainly for convenience are not covered. **The Plan does not cover any of the following:**

- 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.

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

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

**Mobile Cardiac Outpatient Telemetry** - (MCOT) is not covered.

**Morbid Obesity** treatment including gastric bypass surgery, other surgeries, services or drugs 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 covered.

**Newborns** or other children of a Covered Dependent Child are not covered.

## O

**Obstetrical Care Home births** are not covered.

**Oral Surgery services** listed below are not covered:

- Oral surgery which is part of an orthodontic treatment program;
- Orthodontic treatment prior to orthognathic surgery;
- Dental implants or dentures and any preparation work for them;
- Extraction of wisdom teeth.

**Orthoptics** or vision or visual training and any associated supplemental testing are not covered.

**For Vantage HMO Plans Out-of-Network Medical, Mental Health, and Laboratory Services** You receive from Non-Plan Providers, whether referred or directed by a Plan Provider, are not covered. Medically Necessary Covered Services provided by a Non-Plan Provider during an Emergency, or during an authorized Admission to a Plan Facility, will be Covered under In-Network benefits.

**For POS and Plus PPO plans Out-of-Network Medical, Mental Health, and Laboratory Services** You receive from Non-Plan Providers, whether referred or directed by a Plan Provider, are covered under Out-of-Network benefits only. Medically Necessary Covered Services provided by a Non-Plan Provider during an Emergency, or during an authorized Admission to a Plan Facility, will be Covered under In-Network benefits.

**Over the Counter Medications** are not covered.

## P

**PARS System** (Physical Activity Reward System) is not covered.

**Pass Devices** (Patient Activated Serial Stretch) are not covered.

**Paternity Testing** is not covered.

**Penile implants** are not covered.

**Personal comfort items** are not covered. 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.

**For Vantage HMO Plans Physician Examinations** are limited as follows:

- Physicals for employment, insurance or recreational activities are not covered.
- Executive physicals are not covered.
- A second opinion from a Non-Plan Provider is covered only when authorized by the Plan. 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.

**For POS and Plus PPO Plans Physician Examinations** are limited as follows:

- Physicals for employment, insurance or recreational activities are not covered.
- Executive physicals are not covered.
- A second opinion from a Non-Plan Provider is covered only under 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.

**Physician's Clerical Charges** are not covered. 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.

**Private Duty Nursing** is not covered.

**Pulsed Irrigation Evacuation System** is not covered

## Q

## R

**Reconstructive surgery** - is not covered 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 covered subject to the Plan's Medical Necessity determination. Emotional conflict or distress does not constitute Medical Necessity. Breast reconstruction following mastectomy is covered.

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

**Residential or Sub-Acute Level of Care** or treatment is not covered.

## S

**For Vantage HMO Plans Second Opinions** from Plan providers do not require authorization. A second opinion from a Non-Plan provider is covered only when a Plan provider is not available.

**For POS and Plus PPO Plans** a Second Opinion from a Non-Plan Provider is covered under Out-of-Network Benefits only. A second opinion from a Plan Provider does not require authorization.

**Services.** The Plan does not cover any of the following:

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

**Sterilization**

- Reversal of voluntary sterilizations is not covered.
- Any infertility services required because of a reversal are not covered.

## T

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. Therapies will be covered only to the extent of restoration to the level of the pre-trauma, pre-illness or pre-condition status. **The Plan does not cover any of the following except for those services that are covered through Early Intervention benefits:**

- 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 covered.

**Transplant Services**. **The Plan does not cover 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;
- Travel and lodging services not approved by the Plan including childcare, mileage, and rental cars.

**For Vantage HMO Plans Travel and Lodging** expenses are not Covered Services unless authorized by the Plan for Members traveling for Transplant Services. Treatment and Covered Services, other than Emergency Services, received outside of the United States of America are not covered.

**For POS and Plus PPO Plans Travel and Lodging expenses are not Covered Services unless authorized by the Plan for Members traveling for Transplant Services. Treatment and Covered Services, other than Emergency Services, received outside of the United States of America are covered under Out-of-Network benefits only.**

**Transportation**. Ambulance services that are not Emergency Services are only covered when approved and authorized by Us.

**U**

**V**

**Video Recording or Video Taping** of any covered service procedure is not covered.

Treatment of **Varicose Veins or telangiectatic dermal veins** (spider veins) for cosmetic purposed are not covered.

**Vision Exams and Materials** not listed under Covered Services are not covered.

**W**

**Wigs or cranial prostheses** for hair loss for any reason are not covered.

**Wisdom Teeth** extraction is not covered.

**Work-related** injuries or diseases when the employer must provide benefits or when that person has been paid by the employer are not covered.

**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 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 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 Optima.

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 Optima benefit and not allowed by the applicable chiropractic scope of practice.

23. Any services provided by a person who is a family member. 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.

24. 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.

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

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