EXCLUSIONS AND LIMITATIONS

OptimaFit® and OptimaFit® Select

Individual Product OFF Exchange

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.

Underwritten By Optima Health Plan

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This following are 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 is a Covered Service in the first 12 weeks of pregnancy. After 12 weeks abortion is a Covered Service if the mother's life is at risk, if there are major fetal abnormalities, or in the case of rape or incest.

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. Benefits will not be given for any illness or injury that is a result of war, service in the armed forces, a nuclear explosion, nuclear accident, release of nuclear energy, a riot, or civil disobedience. In addition, benefits may not be able to be provided or may be delayed in the event of a major disaster.

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

Administrative Charges including charges to complete claim forms, charges to get medical records or reports and membership, administrative, or access fees charged by Doctors or other Providers are not Covered Services. Examples include, but are not limited to, fees for educational brochures or calling you to give you test results.

Alternative or Complementary Medicine services or treatments are not Covered Services. This includes, but is 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); or
- Colonic irrigation.

Ambulance Service for transportation for services that are not Emergency Services is not a Covered Service unless We authorize the transportation service.

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

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

Applied Behavioral Analysis is not a Covered Service**.**

Autopsies are not a Covered Service.

B

Batteries are not a Covered Service except for motorized wheelchairs and cochlear implants when authorized.

Biofeedback Therapy, neurofeedback, and related testing are not Covered Services unless We authorize them.

Birthing Center Services are Covered Services at contracted facilities only.

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 We authorize them.

Bone or Joint treatment involving a bone or joint of the head, neck, face or jaw is covered like any other bone or joint of the skeletal structure. 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 Services unless We have approved them.

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

Breast Ductal Lavage is not a Covered Service.

Breast Milk from a donor is not a Covered Service.

C

Charges for services not described, documented or supported in your medical records are not Covered Services.

Chelation Therapy is not a Covered Service except for arsenic, copper, iron, gold, mercury or lead poisoning.

Complications of Non-covered Services are not covered. This includes care that is needed as a direct result of a Non-covered Service and without the Non-covered Service, care would not have been needed.

Cosmetic Services are not Covered Services. This includes treatments, surgery, services, Prescription Drugs, equipment, or supplies given for cosmetic services. Cosmetic services are meant to preserve, change or improve how a person looks and not Medically Necessary. Emotional conflict or distress is not considered by the Plan when determining if a service or procedure is Medically Necessary. **We will not cover any of the**

following:

- Services to preserve, change or improve how a person looks or to change the texture or look of skin, the size, shape or look of facial or body features;
- Surgery, reconstructive surgery, or other procedures that are cosmetic and not Medically Necessary to restore function or alleviate symptoms which can effectively be treated non-surgically;
- Any service or supply that is a direct result of a non-covered service;
- 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; or
- Vitiligo **or other cosmetic skin condition** treatments by laser, light or other methods.

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 are not a Covered Service under the Plan. This exclusion applies even when services are recommended by a professional or performed in a facility, such as a hospital or skilled nursing facility, or at home. This exclusion does not apply to hospice care.

D

Dentistry/Oral Surgery/Adult Dental Care

The following services are not Covered Services. This exclusion does not apply to services under the Plan's Pediatric Oral Care Benefit:

- Treatment of natural teeth due to disease;
- Routine dental care and 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, prosthodontal, or orthodontic care;
- Cosmetic services to restore appearance;
- Restorative services and supplies necessary to treat, repair or replace sound natural teeth 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 which is part of an orthodontic treatment program is not covered; or
- Orthodontic care.

Disposable Medical Supplies are not Covered Services. Medical dressings, disposable diapers, over the counter supplies, bandages, tape, gauze pads, alcohol, iodine, peroxide and other disposable supplies are not Covered Services.

Donor Benefits are not Covered Services if the covered individual is donating an organ to a non-covered member. When the donor is a non-covered member and the person receiving the organ is covered, benefits are limited to benefits not available to the donor from any other source.

Driver Training is not a Covered Service.

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

The following are not Covered Services and are not included in the Plan's Coverage of Durable Medical Equipment (DME): appliances, devices, and medical supplies that have both a non-therapeutic and therapeutic use, including exercise equipment; air conditioners, purifiers, and humidifiers; first aid supplies or general use items such as heating pads, thermometers, and bandages; hypoallergenic bed lines; raised toilet seats; shower chairs; whirlpool baths, waterbeds and hot tubs; handrails, ramps, elevators, and stair glides; telephones; adjustments made to vehicles;; changes made to home or businesses; clothing articles, except those needed after surgery or injury; or repair or replacement of equipment lost or damaged through neglect. Durable Medical Equipment not appropriate for use in the home is not a Covered Service.

E

Electron Beam Computer Tomography (EBCT) is not a Covered Service.

Educational, Vocational, or Self-training services or supplies are not Covered Services. Services, treatment or testing required to complete **Educational Programs,** degree requirements, or residency requirements are not Covered Services.

Educational Testing, Evaluation, Screening, or tutorial services are not Covered Services. Any other service related to school or classroom performance is not a Covered Service**.** This does not include services that qualify as Early Intervention Services or when received as part of a covered wellness visit or screening.

Examinations, testing or treatment required for employment, insurance, or judicial or administrative proceedings are not a Covered Service.

Exercise Equipment is not a Covered Service. This includes bicycles, treadmills, stair climbers, free weights, exercise videos, or any other exercise equipment. This also includes pool, gym, or health club membership fees.

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;
- 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;
- The research regarding this drug, device, medical treatment or procedure may be so limited that an evaluation of safety and efficacy cannot be made;
- The drug or device is not approved for marketing by the United States Food and Drug Administration (FDA);

- 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, and corrective or protective eyewear required for work are not a Covered Service.

Eye Exercises, Eye Movement Desensitization and Reprocessing Therapy are not Covered Services.

Eye Corrective Surgery such as Radial Keratotomy, PRK, or LASIK is not a Covered Service.

F

Services provided by **Family Members** are not Covered Services. This includes services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.

Palliative or cosmetic **Foot Care Services** are not Covered Services 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 except for Members with Diabetes or vascular disease;
- Fallen arches;
- Weak feet;
- Tarsalgia;
- Metatarsalgia; or
- 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.

G

GIFT programs (Gamete Intrafallopian Transfer) are not a Covered Service.

Group Speech Therapy is not a Covered Service.

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

H

Health club memberships, health spa charges, exercise equipment or classes, charges from a physical fitness instructor or personal trainer, and other charges for services, equipment or facilities for developing or maintaining physical fitness are not Covered Services. This exclusion applies even when services are ordered by a physician.

Hearing Aids are not Covered Services. Examinations, fittings, molds, batteries or other supplies are not Covered Services. This does not apply to cochlear implants or screenings covered under Preventive Care Benefits.

Home Births are not covered. The Plan's provider network does not include midwives. Delivery by midwife is only covered at In-Network Plan participating birthing centers.

Home Health Care Skilled Services are not Covered Services unless You are homebound**.** Services are limited as stated on Your Plan's face sheet or schedule of benefits. We do not cover any services after You have reached Your Plan's limit. We only cover services or supplies listed in Your home health care plan. We do not cover custodial care unless it is rendered as part of hospice care. We do not cover transportation. 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 are not covered 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; or
- Care by interns, residents, house physicians, or other facility employees that are billed separately from the facility.

Hypnotherapy is not a Covered Service.

I

Immunizations required for foreign travel or for employment are not Covered Services, unless such services are received as part of the covered preventive care services.

Implants for cosmetic breast enlargement are not Covered Services. We do not cover cosmetic procedures or cosmetic surgery for breast enlargement or reduction. We do 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.

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/ZIFT programs;
- Reproductive material storage;
- Treatment or testing related to sexual organ function, dysfunction or inadequacies, including but not limited to, impotency;
- Semen recovery or storage;

- Sperm washing;
- Services to reverse voluntary sterilization;
- Infertility Treatment or services from reversal of sterilization;
- Drugs used to treat infertility; or
- Surrogate pregnancy services.

J

K

Keloids from body piercing or pierced ears are not Covered Services.

L

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.

Laser Therapy for Vitiligo **or any other cosmetic skin conditions** is not a Covered Service**.**

Lasik Surgery is not a Covered Service.

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

M

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

Maximum Benefit Limits are stated on Your Plan's Face Sheet or Schedule of Benefits. We do not cover any additional benefits after a benefit visit limit has been reached.

Medical Equipment, Devices and Supplies that are disposable or mainly for convenience are not Covered Services. **We do 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; or
- Over the counter supplies, such as bandages, tape, gauze pads, alcohol, iodine, peroxide.

Medical Nutritional Therapy and nutrition counseling are not Covered Services except when provided as part of diabetes education or when received as part of covered wellness services or screening visits, or Hospice Care. 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.

Services and supplies deemed **Not Medically Necessary** are not Covered Services.

Medicare Services are not Covered Services for those eligible for Medicare due to age. This includes services for which benefits are payable under Medicare Parts A, B, and/or D, or would have been payable if you had applied for Parts A and/or B, except as listed in this Evidence of Coverage or as required by federal law, as described in the section titled "Medicare" in "General Provisions." If you do not enroll in Medicare Part B, when you are eligible due to age, We will calculate benefits as if you had enrolled. You should sign up for Medicare Part B as soon as possible to avoid large out-of-pocket costs.

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

Charges for **Missed Appointments or Cancelled Appointments** are not Covered Services.

Mobile Cardiac Outpatient Telemetry (MCOT) is not a Covered Service.

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

N

Neuropsychological Services including psychological examinations, testing or treatment to obtain or keep employment or insurance, or related to judicial or administrative proceedings are not Covered Services unless approved by the Plan.

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

Nutritional or Dietary Supplements are not Covered Services except for those we must cover by law. This Exclusion includes, but is not limited to, nutritionalformulas and dietary supplements that You can buy over the counter and those You can get without a written Prescription or from a licensed pharmacist.

O

Obesity surgery, services, drugs or supplies related to weight loss or dietary control are not Covered Services**.** Any service or supply that is a direct result of a non-covered service is also not a Covered Service. Services to improve appearance following gastric bypass surgery, such as abdominoplasties, panniculectomies and lipectomies are not Covered Services.

Oral Surgery services listed below are not Covered Services unless covered under the Plan's Pediatric Oral Benefits:

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

Orthoptics or vision or visual training and any associated supplemental testing are not Covered Services.

Out-Of-Network Medical, Mental Health, and Laboratory Services You receive from Non-Plan Providers 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.

Over the counter convenience and hygienic items are not Covered Services**.**

P

Paternity Testing is not Covered Services.

Penile implants are not Covered Services.

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

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

- Physicals for employment, insurance or recreational activities are not Covered Services.
- Executive physicals are not Covered 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.

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

Private Duty Nursing in an Inpatient setting is not a Covered Service.

Prosthetics for sports or cosmetic purposes are not Covered Services. This includes wigs and scalp hair prosthetics except for one wig per benefit year following cancer treatment.

Non-Covered **Providers** and services provided including massage therapists, physical therapist technicians, and athletic trainers.

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.

Residential Treatment Center Care or care in another non-skilled settings are not Covered Services unless the treatment setting qualifies as a substance use disorder treatment facility licensed to provide continuous, structured, 24 hour a day program of drug or alcohol treatment and rehabilitation including 24 hour a day nursing care, and services are not merely custodial, residential, or domiciliary in nature.

S

Second Opinions – A second opinion from a Non-Plan Provider is covered only when authorized by the Plan.

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 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; or
- Any service or supply that is a direct result of a non-covered service.

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

Inpatient services during a temporary leave from a **Skilled Nursing Facility** are not Covered Services unless authorized by the Plan. Private rooms are not Covered Services unless Medically Necessary.

Reversal of voluntary **Sterilization** is not a Covered Service. Infertility services required because of a voluntary reversal are not Covered Service.

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.

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

Therapies - Physical, Speech, and Occupational **Therapies** are limited as stated on Your face sheet or schedule of benefits. **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;
- Sleep therapies;
- Driver evaluations as part of occupational therapy;
- Driver training;
- Functional capacity testing needed to return to work;
- Work hardening programs; or
- Gambling therapies.

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; and
- Travel and lodging services not approved by the Plan including child care, mileage, rental cars.

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 while You are traveling are not covered.

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

U

Urea Breath Testing is not a Covered Service**.**

V

Vaccines are not covered unless approved by the Plan.

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

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

Virtual Colonoscopy is not a Covered Service unless approved by the Plan.

Adult **Vision** services or supplies are not Covered Services unless needed due to eye surgery or accidental injury, including routine vision care and materials except as outlined in the document and eyeglasses and eyewear except as outlined in this document. Sunglasses or safety glasses and accompanying frames are not Covered Services**.**

Vitiligo Treatments by laser, light or other methods is not a Covered Service.

W

Weight Loss Programs are not Covered Services. This includes programs, whether or not under medical supervision including, but not limited to commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

Weight Loss Surgery/Bariatric surgery is not a Covered Surgery. This includes but is not limited to Roux-en-Y (RNY),Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgeries lower stomachcapacity and divert partly digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty (surgeries that reduce stomach size), or gastric banding procedures.

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

Extraction of erupted or impacted **Wisdom Teeth** are not Covered Services unless covered under the Plan's Pediatric Oral Care Benefits**.**

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 COVERAGE EXCLUSIONS AND LIMITATIONS
Prescription Drug Coverage Limitations and Other Coverage Terms and Conditions

The following is a list of limitations and conditions on Your Outpatient Prescription Drug Covered Services:

1. At its sole discretion Optima Health's Pharmacy and Therapeutics Committee determines which Tier a covered drug is placed in. The Plan's Pharmacy and Therapeutics Committee is composed of physicians and pharmacists. For all drugs including those new to market the committee looks at the medical literature and then evaluates whether to add or remove a drug from the preferred/standard drug list. Efficacy, safety, cost, and overall disease cost are factors that are taken into consideration. The Pharmacy and Therapeutics Committee may establish monthly quantity Limits for selected medications.
2. Only drugs and self-administered injectables that You pick up at a retail pharmacy or receive from the Plan's mail order benefit or specialty pharmacy are Covered under the Plan's Outpatient Prescription Drug Benefit. Prescription medications and supplies ordered and administered by Your Provider as part of a doctor's visit, home health care visit or at an outpatient or inpatient facility are Covered Services under the Plan's medical benefits. See "Medications Administer By A Medical Provider" in the EOC.
3. Members must pay Copayment, Coinsurance, and Deductible amounts directly to the pharmacy provider for a Covered prescription drug.
4. Prescriptions may be filled at a Plan pharmacy or a non-participating pharmacy that has agreed to accept as payment in full reimbursement from the Plan, including any Copayment or Coinsurance consistently imposed by the plan, at the same level as the Plan gives to participating pharmacies. Drugs that are Specialty Drugs are only available through the Plan's Specialty Pharmacy provider.
5. All covered outpatient prescription drugs must have been approved by the Food and Drug Administration and require a prescription either by state or federal law.
6. Amounts You pay for any outpatient prescription drug that is excluded from Coverage will not count toward any Plan Maximum Out-of-Pocket Limit.
7. All compounded prescriptions require Pre-Authorization and must contain at least one prescription ingredient in order to be covered.
8. Some Covered Services require Pre-Authorization by the Provider before You receive services. We have instructions and procedures in place for Providers to obtain Pre-Authorization. You can call Member Services at the number on Your ID card to verify that Your services have been pre-authorized.
9. Benefits will not be denied for any drug prescribed, on an inpatient or outpatient basis, to treat a covered indication so as long as the drug has been approved by the United States Food and Drug Administration for at least one indication and the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.
10. Benefits will not be denied for any drug, prescribed on an inpatient or outpatient basis, approved by the United States Food and Drug Administration for use in the treatment of cancer on the basis that the drug has not been approved by the United States Food and Drug Administration for the treatment of specific type of cancer for which the drug has been prescribed, provided the drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the standard reference compendia.
11. Benefits will not be denied for any drug, prescribed on an inpatient or outpatient basis, approved by the United States Food and Drug Administration for use in the treatment of cancer pain for the reason that the dosage is in excess of the recommended dosage of the pain relieving agent, if the prescription has been prescribed for a person with intractable cancer pain.

12. Covered Food and Drug Administration (FDA) approved tobacco cessation medications (including both prescription and over-the-counter medications) are Limited to two 90 day courses of treatment per year when prescribed by a health care provider.
13. We may approve Coverage of limited quantities of an OTC drug. You must have a Physician's prescription for the drug, and the drug must be included on the Plan's list of covered Preferred and Standard drugs. Medications that are required to be covered under state and federal law under the Plan's Preventive benefits will be covered at the generic product level with no Member cost sharing when received from Plan Providers.
14. **OptimaFit and OptimaFit Select plans:** Self-injected insulin and related supplies including syringes, and needles are covered under the prescription drug benefit. Member cost sharing is determined by the applicable Tier. Diabetic testing supplies including home blood glucose monitors, test strips, lancets, lancet devices, and control solution, are covered with no Member cost sharing and the Deductible does not apply. LifeScan products will be the sole preferred brand. Members can pick up supplies at any network pharmacy. Diabetes education and nutritional therapy are covered under the Plan's Medical Benefits.

    OptimaFit HSA plans: Self-injected insulin and related supplies including syringes and needles are covered under the Outpatient Prescription Drug Benefit. Diabetic supplies and equipment, other than those listed above, and in-person outpatient self-management training and education, including medical nutrition therapy, for the treatment of Diabetes are covered under the Plan's Medical Benefits for Diabetes Care Management.

Prescription Drug Coverage Non-Covered Services List of Exclusions
The following is a list of exclusions of Non-Covered Services that apply to Your Outpatient Prescription Drug benefits.

1. Any prescription drugs, over the counter drugs, or devices that are not included on the Plan's Prescription Drug Formulary are not Covered Services.
2. Medications that do not meet the Plan's criteria for Medical Necessity are not Covered Services.
3. Prescription medications ordered and administered by Your Provider as part of a doctor's visit, home health care visit or at an outpatient or impatient facility are Covered only under the Plan's medical benefits. This includes, but is not limited to immunization agents, biological sera, blood, or blood products covered under the Plan's medical benefits. A drug covered under the Plan's medical benefits will not also be covered under the Plan's Outpatient Prescription drug benefit.
4. Medications with no approved FDA indications are not Covered Services.
5. Compound prescription medications with ingredients not requiring a Physician's authorization by state or federal law are not Covered Services.
6. Over-the-counter (OTC) medications that do not require a Physician's authorization by state or federal law and any prescription that is available as an OTC medication are not Covered Services. This does not apply to OTC medications We are required by state or federal law to cover under Preventive Care benefits.
7. Non-durable disposable medical supplies and items such as bandages, cotton swabs, hypodermic needles, and durable medical equipment not listed as covered are not Covered Services.
8. Injectables (other than those self-administered and insulin) are not Covered Services under the Plan's prescription drug benefit.
9. Medication taken or administered in whole or in part, while a Member is a patient in a licensed Hospital is not a Covered Service under the Plan's prescription drug benefit.
10. Medications for cosmetic purposes only, including but not Limited to Retin-A for aging, are not Covered Services.
11. Medications for experimental indications and/or dosage regimens determined by the Plan to be Experimental are not Covered Services.

12. Therapeutic devices or appliances, including but not Limited to support stockings and other medical/non-medical items or substances, regardless of their intended use are not Covered Services.
13. Drug charges exceeding the cost for the same drug in a conventional packaging (i.e., convenience packages, unit doses, blister packs, etc.) are not Covered Services.
14. Drugs with a therapeutic over-the-counter (OTC) equivalent are not Covered Services.
15. Certain off-label drug usage is excluded from Coverage unless the use has been approved by the Plan.
16. Compound drugs are not Covered Services when alternative products are commercially available.
17. Cosmetic health and beauty aids are not Covered Services.
18. Drugs purchased from Non-Plan Providers over the internet are not Covered Services.
19. Drugs purchased through a foreign pharmacy are not Covered Services unless approved by the Plan for an emergency while traveling out of the country.
20. Flu symptom drugs are not Covered Services unless approved by the Plan.
21. Human growth hormone for the treatment of idiopathic short stature is not a Covered Service.
22. Medical Foods, nutritional formulas and dietary supplements that can be purchased over the counter, or which by law do not require either the written prescription or dispensing by a licensed pharmacist are not Covered Services.
23. Drugs not meeting the minimum levels of evidence based on one or more of the following Standard reference compendia are not Covered Services:
    a. American Hospital Formulary Service Drug Information;
    b. National Comprehensive Cancer Network's Drugs & Biologics Compendium; or
    c. Elsevier Gold Standard's Clinical Pharmacology.
24. Minerals, fluoride, and vitamins are not Covered Services unless determined to be Medically Necessary to treat a specifically diagnosed Illness or when included under ACA Recommended Preventive Care.
25. Pharmaceuticals approved by the FDA as a medical device not Covered Services.
26. Drugs used to inhibit and/or suppress drowsiness, sleepiness, tiredness, or exhaustion, unless authorized by the Plan are not Covered Services.
27. Prescriptions written by a licensed dentist are not Covered Services, except for the prevention of infection or pain in conjunction with a Covered dental procedure.
28. Raw powders or chemical ingredients are not Covered Services unless approved by the Plan or submitted as part of a compounded prescription.
29. Drugs to treat sexual dysfunction including erectile dysfunction drugs are not Covered Services.
30. Onychomycosis drugs (toenail fungus) are not Covered Services except when we allow it to treat members who are immune-compromised or diabetic.
31. Travel related medications, including preventive medication for the purpose of travel to other countries are not Covered Services.
32. Infertility drugs are not Covered Services.
33. Prescription or over the counter appetite suppressants and any other prescription or over the counter medication for weight loss are not Covered Services.
34. Charges for delivery of drugs.

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 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 Health.
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 an immediate family member. 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).

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.

PEDIATRIC ORAL SERVICES EXCLUSIONS AND LIMITATIONS

The following are not Covered Benefits **unless specifically identified** as a Covered Benefit:

1. Services or supplies that are not considered Dental Services are not covered under the Pediatric Oral benefit.
2. Services or treatment provided by someone other than a licensed Dentist or a qualified licensed dental hygienist working under the supervision of a Dentist are not covered.
3. A Dental Service that is determined not to be necessary or customary for the diagnosis or treatment of Your condition will not be covered. In making this determination, the Plan will take into account generally accepted dental practice standards based on the Dental Services provided. In addition, each Covered Benefit must demonstrate Medical Necessity and be determined to be in accordance with generally accepted standards of dentistry.
4. Dental Services for injuries or conditions that may be covered under workers compensation, similar employer liability laws or other medical plan coverage are not covered.
5. Benefits or services that are available under any federal or state government program (subject to the rules and regulations of those programs) or from any charitable foundation or similar entity are not covered.
6. Dental services provided before the date You enrolled under this plan are not covered.
7. Dental services provided after the date You are no longer enrolled or eligible for coverage are not covered.
8. Except as otherwise provided, prescription and non-prescription drugs; pre-medications; preventive control programs, oral hygiene instructions, and relative analgesia are not covered under the Pediatric Oral Care benefit. Prescription drugs may be covered under the Plan's medical benefits.

9. Charges for inpatient or outpatient hospital services; any additional fee that the Dentist may charge for treating a patient in a hospital, nursing home or similar facility are not covered under the pediatric oral benefit.
10. Charges to complete a claim form, copy records, or respond to requests for information are not covered.
11. Charges for failure to keep a scheduled appointment are not covered.
12. Charges for consultations, by phone or by other electronic means are not covered.
13. Dental services to the extent that benefits are available or would have been available if You had enrolled, applied for, or maintained eligibility under Title XVIII of the Social Security Act (Medicare), including any amendments or other changes to that Act are not covered.
14. Complimentary services or dental services for which You would not be obligated to pay in the absence of the coverage under this plan or any similar coverage are not covered.
15. Services or treatment provided to an immediate family member by the treating dentist are not covered. This would include a dentist's parent, spouse or child.
16. Dental services and supplies for the replacement device or repeat treatment of lost, misplaced or stolen prosthetic devices including space maintainers, bridges and dentures (among other devices) are not covered.
17. Cosmetic surgery or dentistry for cosmetic purposes is not covered.
18. Replacement of congenitally missing teeth by dental implant, fixed or removable prosthesis whether the result of a medical diagnosis including but not limited to hereditary ectodermal dysplasia or not related to a medical diagnosis is not covered under the Pediatric Oral benefit.
19. Experimental or investigative dental procedures, services, supplies as well as services and/or procedures due to complications thereof are not covered. Experimental or investigative procedures, services or supplies are those which, in the judgment of the Delta Dental: (a) are in a trial stage; (b) are not in accordance with generally accepted standards of dental practice, or (c) have not yet been shown to be consistently effective for the diagnosis or treatment of the Enrollee's condition.
20. Amounts assessed on dental services and/or supplies by state or local regulation are not covered.
21. Non-medically necessary orthodontic treatment is not covered.

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.
2. Aniseikonic lenses are not covered.
3. Medical and/or surgical treatment of the eye, eyes or supporting structures are covered under the Optima Health Medical Benefit.
4. Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment is not covered.
5. Safety eyewear is not covered.
6. 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.
7. Plano (non-prescription) lenses and/or contact lenses are not covered.
8. Non-prescription sunglasses are not covered.

9. Two pair of glasses in lieu of bifocals are not covered.
10. 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.
11. 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.