Maryland OAP Network Exclusions and Limitations (Medical)

Exclusions And Limitations: What Is Not Covered By This Policy

Excluded Services

In addition to any other exclusions and limitations described in this Policy, there are no benefits provided for the following:

- Services or supplies that are **not Medically Necessary**.
- Services performed or prescribed under the direction of **a person who is not a licensed health care practitioner**.
- Services that are **beyond the scope of practice** of the Provider performing the service.
- Services from any Provider or health care entity when an Insured Person receives a referral to that Provider or health care entity from a Physician when:
    - The Physician making the referral has a beneficial interest, alone or in combination with his or her immediate family, in that Provider or health care entity; or
    - The immediate family of the Physician making the referral owns a beneficial interest of 3% or greater in that Provider or health care entity;
    - The Physician making the referral, alone or in combination with his or her immediate family, has a compensation arrangement with that Provider or health care entity; or
    - The appropriate regulatory board determines the services were provided as the result of a prohibited referral.
- Any **services for which payment may be obtained from any local, state or federal government agency** (except Medicaid). Veterans Administration Hospitals and Military Treatment Facilities will be considered for payment according to current legislation.
- Services **for which You have no legal obligation to pay** or for which no charge would be made if You did not have health plan or insurance coverage.
- **The purchase, examination or fitting of eyeglasses or contact lenses**, except for aphakic patients and also for rigid gas permeable lenses or sclera shells intended for use in the treatment of a disease or injury; this exclusion does not apply to Pediatric Vision benefits.
- **Personal care services** and domiciliary care services
- Services **rendered by a health care practitioner who is** an Insured Person's spouse, mother, father, daughter, son, brother, or sister
- Services or supplies that are considered to be for **Experimental Procedures or Investigative Procedures**.
- An **eye surgery** that is **not Medically Necessary.**
- Services to **reverse a voluntary sterilization** procedure;
- Services for sterilization or reverse sterilization **for a dependent minor**; this exclusion will not apply to FDA-approved sterilization procedures for women with reproductive capacity.
- Services primarily for **weight reduction or treatment of obesity including morbid obesity**, or any care which involves weight reduction as a main method for treatment except as otherwise specifically stated in this Policy.
- Services **received before the Effective Date of coverage**.

- Services **received after coverage under this Policy ends,** including any extension of benefits.
- **Cosmetic surgery** or other services for beautification, to improve or alter appearance or self-esteem or to treat psychological or psychosocial complaints regarding one's appearance including macromastia or gynecomastia surgeries; surgical treatment of varicose veins; abdominoplasty/panniculectomy; rhinoplasty. This exclusion does not apply to Reconstructive Surgery to restore a bodily function or to correct a deformity caused by Injury or congenital defect of a Newborn child, or for Medically Necessary Reconstructive Surgery performed to restore symmetry incident to a mastectomy or lumpectomy.
- Any condition for which benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, **under any workers' compensation, employer's liability law or occupational disease law**, to the extent the Insured Person is required to be covered by a workers' compensation law.
- Services rendered from a **dental or medical department maintained by or on behalf of an employer**, mutual benefit association, labor union, trust, or similar persons or groups.
- **Items which are furnished primarily for personal comfort or convenience** (air purifiers, air conditioners, humidifiers, exercise equipment, treadmills, spas, elevators and supplies for hygiene or beautification, including cranial prostheses, etc.).
- Charges for **Telephone consultations, failure to keep a scheduled appointment,** or for **completion of any form**.
- Inpatient room and board **charges in connection with a Hospital stay primarily for diagnostic tests** which could have been performed safely on an outpatient basis.
- Purchase, examination or fitting of **Hearing aids** and supplies including but not limited to semi-implantable hearing devices, audient bone conductors and Bone Anchored Hearing Aids (BAHAs), except as specifically stated in this Policy. For the purposes of this exclusion, a hearing aid is any device that amplifies sound.
- Except for covered ambulance services or as otherwise stated in this Policy, **travel,** whether or not recommended by a health care practitioner;
- Any **services received while the covered person is outside the United States** except for emergency services.
- **immunizations related to foreign travel**.
- Unless otherwise specified in this Plan, **dental work or treatment** which includes hospital or professional care in connection with:
    - The operation or treatment for the fitting or wearing of dentures,
    - Orthodontic care or malocclusion,
    - Operations on or for the treatment of or to the teeth or supporting tissues of the teeth, except for removal of tumors and cysts or treatment of injury to natural teeth due to an accident if the treatment is received within 6 months of the accident;
    - Dental implants - Dental materials implanted into or on bone or soft tissue or any associated procedure as part of the implantation or removal of dental implants
- **Accidents occurring while** and as a result **of chewing**; this exclusion does not apply to Pediatric Dental benefits.
- **Routine foot care** including the cutting or removal of corns or calluses; the trimming of nails, unless the services are determined to be Medically Necessary.
- **Orthopedic shoes** (except when joined to braces), arch supports, shoe inserts, foot orthotic devices.

- **Inpatient admissions primarily for physical therapy**, unless authorized by Cigna.
- **Treatment of sexual dysfunction**, impotence and/or inadequacy except if this is a result of an Accidental Injury, organic cause, trauma, infection, or congenital disease or anomalies.
- Services that duplicate benefits provided under federal, State or local laws, regulations or programs;
- Charges for **animal to human organ transplants**.
- Fees for **non-replacement** of blood and blood products; associated with the **collection or donation of blood or blood products**, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- **Lifestyle improvements, nutritional counseling or food supplements**, except as stated in this Policy, physical fitness programs.
- **Wigs or cranial prosthetics,** except as specifically stated in this Policy.
- **Weekend admission charges**, except for emergencies and maternity, unless authorized by Cigna.
- Outpatient orthomolecular therapy, including nutrients, vitamins and food supplements.
- Services resulting from **accidental bodily injuries arising out of a motor vehicle accident** to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.
- Any services required by state or federal law to be supplied by a public school system, school district or other public institutions.
- Any **amounts in excess of maximum amounts of Covered Expenses** stated in this Policy.
- Services **not specifically listed as Covered Services** in this Policy.

Services Excluded under Medical Benefits, Covered Under Prescription Drug Benefits

The following services are covered under the Prescription Drug Benefits (not under medical benefits) of this Plan:

All **non-prescription Drugs**, devices and/or supplies, except drugs designated as preventive by the Patient Protection and Affordable Care Act (PPACA), that are available over the counter or without a prescription; **Injectable drugs** ("self-injectable medications) **that do not require Physician supervision;**; **All noninjectable prescription drugs, injectable prescription drugs that do not require Physician supervision** and are typically considered self-administered drugs,0020nonprescription drugs, and investigational and experimental drugs, and **Self-administered Injectable Drugs**, except as stated in the Benefit Schedule and in the Prescription Drug Benefits section of this Policy.