

Description of Benefits

This Plan will pay benefits in accordance with any applicable **Florida** Insurance Law(s).

Policy year deductible	In-network coverage	Out-of-network coverage
You have to meet your policy year deductible before this plan pays for additional benefits.		
Student	\$300 per policy year	\$1,000 per policy year
Spouse	\$300 per policy year	\$1,000 per policy year
Child	\$300 per policy year	\$1,000 per policy year
Family	None	None
Policy year deductible waiver		
The policy year deductible is waived for all of the following eligible health services:		
<ul style="list-style-type: none"> In-network care for Preventive care and wellness, Pediatric Vision Care services, and Pediatric Dental Type A services In-network care and out-of-network care for Physician/Specialist Office Visits, Consultants Office visits, Walk-in clinic visits, Well newborn nursery care, Outpatient mental health and substance abuse treatment office visits and Outpatient prescription drugs 		
Maximum out-of-pocket limit per policy year		
Student	\$8,150 per policy year	None
Spouse	\$8,150 per policy year	None
Child	\$8,150 per policy year	None
Family	\$16,300 per policy year	None

Eligible health services	In-network coverage	Out-of-network coverage
Routine physical exams		
Performed at a physician's office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	Not Covered
Maximum age and visit limits per policy year through age 21	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures//Health Resources and Services Administration guidelines for children and adolescents.	
Maximum visits per policy year age 22 and over	1 visit	
Preventive care immunizations		
Performed in a facility or at a physician's office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	Not Covered
Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.	
Routine gynecological exams (including Pap smears and cytology tests)		
Performed at a physician's, obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	Not Covered
Maximum visits per policy year	1 visit	
Preventive screening and counseling services		
Preventive screening and counseling services for Obesity and/or healthy diet counseling, Misuse of alcohol & drugs, Tobacco Products, Depression Screening, Sexually transmitted infection counseling & Genetic risk counseling for breast and ovarian cancer	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	Not Covered
Obesity/Healthy Diet maximum per policy year (Applies to covered persons age 22 and older)	26 visits (10 visits will be allowed under the plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)	

Eligible health services	In-network coverage	Out-of-network coverage
Misuse of Alcohol maximum per policy year	5 visits	
Tobacco Products Counseling maximum per policy year	8 visits	
Depression screening maximum per policy year	1 visit	
STI maximum per policy year	2 visits	
Routine cancer screenings	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	Not Covered
Maximums	Subject to any age; family history; and frequency guidelines as set forth in the most current: <ul style="list-style-type: none"> Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and The comprehensive guidelines supported by the Health Resources and Services Administration. 	
Lung cancer screening maximums	1 screenings every 12 months	
Prenatal care services (Preventive care services only)	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	Not Covered
Lactation support and counseling services	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	Not Covered
Lactation counseling services maximum per policy year	6 visits	
Breast pump supplies and accessories	100% (of the negotiated charge) per item No copayment or policy year deductible applies	Not Covered
Female contraceptive counseling services office visit	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	Not Covered
Eligible health services	In-network coverage	Out-of-network coverage

Contraceptive counseling services maximum per policy year	2 visits	
Female contraceptive prescription drugs and devices	100% (of the negotiated charge) per item No copayment or policy year deductible applies	Not Covered
Female voluntary sterilization- Inpatient & Outpatient provider services	100% (of the negotiated charge) No copayment or policy year deductible applies	Not Covered
Physicians and other health professionals		
Physician, specialist including Consultants Office visits (non-surgical/non-preventive care by a physician and specialist) includes telemedicine consultations	\$40 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit thereafter No policy year deductible applies	\$40 copayment then the plan pays 60% (of the balance of the recognized charge) per visit thereafter No policy year deductible applies
Allergy testing and treatment		
Allergy testing & Allergy injections treatment administered via injection performed at a physician's or specialist's office	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Physician and specialist - surgical services		
Inpatient surgery performed during your stay in a hospital or birthing center by a surgeon (includes anesthetist and surgical assistant expenses)	80% (of the negotiated charge)	60% (of the recognized charge)
Outpatient surgery performed at a physician's or specialist's office or outpatient department of a hospital or surgery center by a surgeon (includes anesthetist and surgical assistant expenses)	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Eligible health services	In-network coverage	Out-of-network coverage
Alternatives to physician office visits		

Walk-in clinic visits (non-emergency visit)	\$40 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit thereafter No policy year deductible applies	\$40 copayment then the plan pays 60% (of the balance of the recognized charge) per visit thereafter No policy year deductible applies
Hospital and other facility care		
Inpatient hospital (room and board) and other miscellaneous services and supplies) Includes birthing center facility charges	\$100 copayment then the plan pays 80% (of the balance of the negotiated charge) per admission thereafter	\$100 copayment then the plan pays 60% (of the balance of the recognized charge) per admission thereafter
In-hospital non-surgical physician services	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Alternatives to hospital stays		
Outpatient surgery (facility charges) performed in the outpatient department of a hospital or surgery center	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Home health Care	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Hospice-Inpatient	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Hospice-Outpatient	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Skilled nursing facility-Inpatient	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Hospital emergency room	\$300 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit	Paid the same as in-network coverage
Non-emergency care in a hospital emergency room	Not covered	Not covered

Important note:

- As out-of-network providers do not have a contract with us the provider may not accept payment of your cost share, (copayment/coinsurance), as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this plan. If the provider bills you for an amount above your cost share, you are not responsible for paying that amount. You should send the bill to the address listed on the back of your ID card, and we will resolve any payment dispute with the provider over that amount. Make sure the ID card number is on the bill.
- A separate hospital emergency room copayment/coinsurance will apply for each visit to an emergency room. If you are admitted to a hospital as an inpatient right after a visit to an emergency room, your emergency room copayment/coinsurance will be waived and your inpatient copayment/coinsurance will apply.

- Covered benefits that are applied to the hospital emergency room copayment/coinsurance cannot be applied to any other copayment/coinsurance under the plan. Likewise, a copayment/coinsurance that applies to other covered benefits under the plan cannot be applied to the hospital emergency room copayment/coinsurance.
- Separate copayment/coinsurance amounts may apply for certain services given to you in the hospital emergency room that are not part of the hospital emergency room benefit. These copayment/coinsurance amounts may be different from the hospital emergency room copayment/coinsurance. They are based on the specific service given to you.
- Services given to you in the hospital emergency room that are not part of the hospital emergency room benefit may be subject to copayment/coinsurance amounts that are different from the hospital emergency room copayment/coinsurance amounts.

Eligible health services	In-network coverage	Out-of-network coverage
Urgent Care	\$50 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit thereafter	\$50 copayment then the plan pays 60% (of the balance of the recognized charge) per visit thereafter
Non-urgent use of urgent care provider	Not covered	Not covered
Pediatric dental care (Limited to covered persons through the end of the month in which the person turns age 19.)		
Type A services	100% (of the negotiated charge) per visit No copayment or deductible applies	60% (of the recognized charge) per visit
Type B services	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Type C services	50% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Orthodontic services	50% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Dental emergency treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Specific Conditions		
Diabetic services and supplies (including equipment and training)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Impacted wisdom teeth	80% (of the negotiated charge)	100% (of the recognized charge)
Accidental injury to sound natural teeth	80% (of the negotiated charge)	100% (of the recognized charge)
Eligible health services	In-network coverage	Out-of-network coverage
Maternity care		

Maternity care (includes delivery and postpartum care services in a hospital or birthing center)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Well newborn nursery care in a hospital or birthing center	80% (of the negotiated charge) No policy year deductible applies	60% (of the recognized charge) No policy year deductible applies
Family planning services – other		
Voluntary sterilization for males-surgical services	80% (of the negotiated charge)	60% (of the recognized charge)
Abortion physician or specialist surgical services	80% (of the negotiated charge)	60% (of the recognized charge)
Gender reassignment (sex change) treatment		
Surgical, hormone replacement therapy, and counseling treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Autism spectrum disorder		
Autism spectrum disorder treatment, diagnosis and testing and Applied behavior analysis	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Physical, occupational, and speech therapy associated with diagnosis of autism spectrum disorder	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Mental Health & Substance Abuse Treatment		
Inpatient hospital (room and board and other miscellaneous hospital services and supplies)	\$100 copayment then the plan pays 80% (of the balance of the negotiated charge) per admission thereafter	\$100 copayment then the plan pays 60% (of the balance of the recognized charge) per admission thereafter
Outpatient office visits (includes telemedicine consultations)	\$40 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit thereafter No policy year deductible applies	\$40 copayment then the plan pays 60% (of the balance of the recognized charge) per visit thereafter No policy year deductible applies
Other outpatient treatment (includes Partial hospitalization and Intensive Outpatient Program)	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit

Eligible health services	In-network coverage Network (IOE facility)	In-network coverage Network (Non-IOE facility)	Out-of-network coverage
Transplant services Inpatient and outpatient facility services	Covered according to the type of benefit and the place where the service is received.		
Transplant services Inpatient and outpatient physician and specialist services	Covered according to the type of benefit and the place where the service is received.		
Eligible health services	In-network coverage	Out-of-network coverage	
Basic infertility services	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	
Specific therapies and tests			
Outpatient diagnostic testing			
Diagnostic complex imaging services performed in the outpatient department of a hospital or other facility	\$300 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit thereafter	60% (of the recognized charge) per visit	
Diagnostic lab work and radiological services performed in a physician's office, the outpatient department of a hospital or other facility	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit	
Outpatient Chemotherapy, Radiation & Respiratory Therapy	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit	
Outpatient physical, occupational, speech, and cognitive therapies (including Cardiac and Pulmonary Therapy) Combined for short-term rehabilitation services and habilitation therapy services	\$40 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit thereafter	\$40 copayment then the plan pays 60% (of the balance of the recognized charge) per visit thereafter	
Chiropractic services	\$40 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit thereafter	\$40 copayment then the plan pays 60% (of the balance of the recognized charge) per visit thereafter	

Eligible health services	In-network coverage	Out-of-network coverage
Other services and supplies		
Emergency ground, air, and water ambulance (includes non-emergency ambulance)	80% (of the negotiated charge) per trip	Paid the same as in-network coverage
Durable medical and surgical equipment	80% (of the negotiated charge) per item	80% (of the recognized charge) per item
Enteral formulas and nutritional supplements	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
Prosthetic Devices & Orthotics	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
Cochlear implants	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
Pediatric vision care (Limited to covered persons through the end of the month in which the person turns age 19)		
Pediatric routine vision exams (including refraction)- Performed by a legally qualified ophthalmologist or optometrist Includes comprehensive low vision evaluations Includes visit for fitting of contact lenses	100% (of the negotiated charge) per visit No policy year deductible applies	60% (of the recognized charge) per visit
Maximum visits per policy year Low vision Maximum Fitting of contact Maximum	1 visit One comprehensive low vision evaluation every policy year 1 visit	
Pediatric vision care services & supplies-Eyeglass frames, prescription lenses or prescription contact lenses	100% (of the negotiated charge) per item No policy year deductible applies	60% (of the recognized charge) per item
Maximum number Per year: Eyeglass frames Prescription lenses Contact lenses (includes non-conventional prescription contact lenses & aphakic lenses prescribed after cataract surgery)	One set of eyeglass frames One pair of prescription lenses Daily disposables: up to 3-month supply Extended wear disposable: up to 6-month supply Non-disposable lenses: one set	
* Important note: Refer to the Vision care section in the certificate of coverage for the explanation of these vision care supplies.As to coverage for prescription lenses in a policy year, this benefit will cover either prescription lenses for eyeglass frames or prescription contact lenses, but not both.		

Eligible health services	In-network coverage	Out-of-network coverage
Outpatient prescription drugs		
Preferred Generic prescription drugs (including specialty drugs)		
For each fill up to a 30 day supply filled at a retail pharmacy	\$15 copayment then the plan pays 100% (of the negotiated charge) No policy year deductible applies	\$15 copayment then the plan pays 100% (of the recognized charge) No policy year deductible applies
Preferred brand-name prescription drugs (including specialty drugs)		
For each fill up to a 30 day supply filled at a retail pharmacy	\$50 copayment then the plan pays 100% (of the negotiated charge) No policy year deductible applies	\$50 copayment then the plan pays 100% (of the recognized charge) No policy year deductible applies
Non-preferred generic prescription drugs (including specialty drugs)		
For each fill up to a 30 day supply filled at a retail pharmacy	\$100 copayment then the plan pays 100% (of the negotiated charge) No policy year deductible applies	\$100 copayment then the plan pays 100% (of the recognized charge) No policy year deductible applies
Non-preferred brand-name prescription drugs (including specialty drugs)		
For each fill up to a 30 day supply filled at a retail pharmacy	\$100 copayment then the plan pays 100% (of the negotiated charge) No policy year deductible applies	\$100 copayment then the plan pays 100% (of the recognized charge) No policy year deductible applies
Preventive care drugs and supplements filled at a retail or mail order pharmacy For each 30 day supply	100% (of the negotiated charge per prescription or refill) No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Risk reducing breast cancer prescription drugs filled at a pharmacy For each 30 day supply	100% (of the negotiated charge) per prescription or refill No copayment or policy year deductible applies	
Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force.	
Tobacco cessation prescription drugs and OTC drugs filled at a pharmacy For each 30 day supply	100% (of the negotiated charge per prescription or refill) No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Maximums:	Coverage is permitted for two 90-day treatment regimens only.	

	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force.
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Exclusions

Acupuncture therapy

- Maintenance treatment
- Acupuncture when provided for the following conditions:
 - Acute low back pain
 - Addiction
 - AIDS
 - Amblyopia
 - Allergic rhinitis
 - Asthma
 - Autism spectrum disorders
 - Bell's Palsy
 - Burning mouth syndrome
 - Cancer-related dyspnea
 - Carpal tunnel syndrome
 - Chemotherapy-induced leukopenia
 - Chemotherapy-induced neuropathic pain
 - Chronic pain syndrome (e.g., RSD, facial pain)
 - Chronic obstructive pulmonary disease
 - Diabetic peripheral neuropathy
 - Dry eyes
 - Erectile dysfunction
 - Facial spasm
 - Fetal breech presentation
 - Fibromyalgia
 - Fibrotic contractures
 - Glaucoma
 - Hypertension
 - Induction of labor
 - Infertility(e.g., to assist oocyte retrieval and embryo transfer during IVF treatment cycle)
 - Insomnia
 - Irritable bowel syndrome
 - Menstrual cramps/dysmenorrhea
 - Mumps
 - Myofascial pain
 - Myopia
 - Neck pain/cervical spondylosis
 - Obesity
 - Painful neuropathies
 - Parkinson's disease

- Peripheral arterial disease (e.g., intermittent claudication)
- Phantom leg pain
- Polycystic ovary syndrome
- Post-herpetic neuralgia
- Psoriasis
- Psychiatric disorders (e.g., depression)
- Raynaud's disease pain
- Respiratory disorders
- Rheumatoid arthritis
- Rhinitis
- Sensorineural deafness
- Shoulder pain (e.g., bursitis)
- Stroke rehabilitation (e.g., dysphagia)
- Tennis elbow/ epicondylitis
- Tension headache
- Tinnitus
- Tobacco Cessation
- Urinary incontinence
- Uterine fibroids
- Xerostomia
- Whiplash

Air or space travel

- Traveling in, on or descending from any aircraft, including a hang glider, while the aircraft is in flight. This includes descending by a parachute, wingsuit or any other similar device.

This exclusion does not apply if:

- You are traveling solely as a fare-paying passenger
- You are traveling on a licensed, commercial, regularly scheduled non-military aircraft
- You are traveling solely in a civil aircraft with a current valid "Standard Federal Aviation Agency Airworthiness Certificate" and:
 - The civil aircraft is piloted by a person with a current valid pilot's certificate with proper ratings for the type of flight and aircraft involved
 - You are as a passenger with no duties at all on an aircraft used only to carry passengers or you are a pilot or a part of the flight crew on an aircraft owned or leased by the policyholder performing duties for the policyholder

Allergy testing and allergy injections treatment

- Allergy sera and extracts administered via injection

Alternative health care

- Services and supplies given by a provider for alternative health care. This includes but is not limited to aromatherapy, naturopathic medicine, herbal remedies, homeopathy, energy medicine, Christian faith-healing medicine, Ayurvedic medicine, yoga, hypnotherapy, and traditional Chinese medicine.

Ambulance services

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- Non-emergency fixed wing air ambulance from an out-of-network provider
 - Non-emergency ambulance transports except as covered under the *Eligible health services under your plan* section of this certificate of coverage

Armed forces

- Services and supplies received from a provider as a result of an injury sustained, or illness contracted, while in the service of the armed forces of any country. When you enter the armed forces of any country, we will refund any unearned pro-rata premium to the policyholder.

Artificial organs

- Any device that would perform the function of a body organ

Behavioral health treatment

- Services for the following categories (or equivalent terms as listed in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association):
 - Stay in a facility for treatment for dementias and amnesia without a behavioral disturbance that necessitates mental health treatment
 - School and/or education service including special education, remedial education, wilderness treatment programs, or any such related or similar programs
 - Services provided in conjunction with school, vocation, work or recreational activities
 - Transportation

Beyond legal authority

- Services and supplies provided by a health professional or other provider that is acting beyond the scope of its legal authority

Blood and body fluid exposure

- Services and supplies provided for the treatment of an illness that results from your clinical related injury as these are covered elsewhere in the student policy

Blood, blood plasma, synthetic blood, blood derivatives or substitutes

Examples of these are:

- The provision of blood to the hospital, other than blood derived clotting factors
- Any related services including processing, storage or replacement expenses
- The services of blood donors, apheresis or plasmapheresis
- For autologous blood donations, only administration and processing expenses are covered

Bones and joints of the facial region expense

- Care or treatment of the teeth or gums
- Intraoral prosthetic device
- Surgical procedures for cosmetic purposes

Breasts

- Services and supplies given by a provider for breast reduction or gynecomastia

Cleft lip/cleft palate

- Oral prosthesis, dentures or bridgework ordered before the **covered dependent** child becomes covered or ordered while covered but installed or delivered more than 60 days after termination of coverage
- Services given to treat speech development unless his/her speech is impaired because of a cleft lip or cleft palate or any condition developed because of cleft lip or cleft palate
- Services performed before the **covered dependent** child becomes covered or after termination of coverage:
 - Hearing aid evaluation tests
 - Oral or facial surgery
 - Cleft orthodontic therapy
 - Diagnostic or rehabilitative
 - Special education for a **covered dependent** child whose ability to speak or hear is lost or impaired including lessons in sign language
 - Hearing examinations required as a condition of employment

Clinical trial therapies (experimental or investigational)

- Your plan does not cover clinical trial therapies (experimental or investigational), except as described in the *Eligible health services under your plan - Clinical trial therapies (experimental or investigational)* section

Clinical trial therapies (routine patient costs)

- Services and supplies related to data collection and record-keeping that is solely needed due to the clinical trial (i.e. protocol-induced costs)
- Services and supplies provided by the trial sponsor without charge to you
- The experimental intervention itself (except medically necessary Category B investigational devices and promising experimental and investigational interventions for terminal illnesses in certain clinical trials in accordance with Aetna's claim policies)
- Select care or in-network coverage limited to benefits for routine patient services provided within the network

Cornea or cartilage transplants

- Cornea (corneal graft with amniotic membrane)
- Cartilage (autologous chondrocyte implant or osteochondral allograft or autograft) transplants

Cosmetic services and plastic surgery

- Any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body. Whether or not for psychological or emotional reasons. Injuries that occur during medical treatments are not considered accidental injuries even if unplanned or unexpected.

This exclusion does not apply to:

- Surgery after an accidental injury when performed as soon as medically feasible
- Coverage that may be provided under the *Eligible health services under your plan - Gender reassignment (sex change) treatment* section.

Court-ordered services and supplies

- This includes court-ordered services and supplies, or those required as a condition of parole, probation, release or as a result of any legal proceeding, unless they are a covered benefit under your plan

Custodial care

Examples are:

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- Routine patient care such as changing dressings, periodic turning and positioning in bed
 - Administering oral medications
 - Care of a stable tracheostomy (including intermittent suctioning)
 - Care of a stable colostomy/ileostomy
 - Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings
 - Care of a bladder catheter (including emptying/changing containers and clamping tubing)
 - Watching or protecting you
 - Respite care except in connection with hospice care, adult (or child) day care, or convalescent care
 - Institutional care. This includes room and board for rest cures, adult day care and convalescent care
 - Help with walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods
 - Any other services that a person without medical or paramedical training could be trained to perform
 - Any service that can be performed by a person without any medical or paramedical training

Dermatological treatment

- Cosmetic treatment and procedures

Dental care for adults

- Dental services for adults including services related to:
 - The care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth
 - Dental services related to the gums
 - Apicoectomy (dental root resection)
 - Orthodontics
 - Root canal treatment
 - Soft tissue impactions
 - Alveolectomy
 - Augmentation and vestibuloplasty treatment of periodontal disease
 - False teeth
 - Prosthetic restoration of dental implants
 - Dental implants

This exception does not include removal of bony impacted teeth, bone fractures, removal of tumors, and odontogenic cysts.

Durable medical equipment (DME)

Examples of these items are:

- Whirlpools
- Portable whirlpool pumps
- Sauna baths
- Massage devices
- Over bed tables
- Elevators
- Communication aids
- Vision aids
- Telephone alert systems
- Personal hygiene and convenience items such as air conditioners, humidifiers, hot tubs, or physical exercise equipment even if they are prescribed by a physician

Educational services

Examples of these services are:

- Any service or supply for education, training or retraining services or testing, except where described in the *Eligible health services under your plan – Diabetic services and supplies (including equipment and training)* section. This includes:
 - Special education
 - Remedial education
 - Wilderness treatment programs (whether or not the program is part of a residential treatment facility or otherwise licensed institution)
 - Job training
 - Job hardening programs
- Educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

Elective treatment or elective surgery

- Elective treatment or elective surgery except as specifically covered under the student policy and provided while the student policy is in effect

Enteral formulas and nutritional supplements

- Any food item, including infant formulas, vitamins, plus prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition, except as covered in the *Eligible health services under your plan – Enteral formulas and nutritional supplements* section

Examinations

Any health or dental examinations needed:

- Because a third party requires the exam. Examples are, examinations to get or keep a job, or examinations required under a labor agreement or other contract
- Because a law requires it
- To buy insurance or to get or keep a license
- To travel
- To go to a school, camp, or sporting event, or to join in a sport or other recreational activity

Experimental or investigational

- Experimental or investigational drugs, devices, treatments or procedures unless otherwise covered under clinical trial therapies (experimental or investigational) or covered under clinical trials (routine patient costs). See the *Eligible health services under your plan – Other services* section.

Emergency services and urgent care

- Non-emergency services in a hospital emergency room facility
- Non-urgent care in an urgent care facility (at a non-hospital freestanding facility)

Facility charges

For care, services or supplies provided in:

- Rest homes
- Assisted living facilities
- Similar institutions serving as a persons' main residence or providing mainly custodial or rest care
- Health resorts
- Spas or sanitariums

- Infirmaries at schools, colleges, or camps

Family planning services - other

- Reversal of voluntary sterilization procedures, including related follow-up care
- Family planning services received while confined as an inpatient in a hospital or other facility
- Services provided as a result of complications resulting from a male voluntary sterilization procedure and related follow-up care

Felony

- Services and supplies that you receive as a result of an injury due to your commission of a felony

Foot care

- Services and supplies for:
 - The treatment of calluses, bunions, toenails, flat feet, hammertoes, fallen arches
 - The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes
 - Supplies (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies
 - Routine pedicure services, such as cutting of nails, corns and calluses when there is no illness or injury of the feet

Gender reassignment (sex change) treatment

- Cosmetic services and supplies such as:
 - Rhinoplasty
 - Face-lifting
 - Lip enhancement
 - Facial bone reduction
 - Blepharoplasty
 - Breast augmentation
 - Liposuction of the waist (body contouring)
 - Reduction thyroid chondroplasty (tracheal shave)
 - Hair removal (including electrolysis of face and neck)
 - Voice modification surgery (laryngoplasty or shortening of the vocal cords), and skin resurfacing, which are used in feminization
 - Chin implants, nose implants, and lip reduction, which are used to assist masculinization, are considered cosmetic

Gene-based, cellular and other innovative therapies (GCIT)

The following are not eligible health services unless you receive prior written approval from us:

- GCIT services received at a facility or with a provider that is not a GCIT-designated facility/provider
- All associated services when GCIT services are not covered. Examples include infusion, laboratory, radiology, anesthesia, and nursing services.

Please refer to the *Medical necessity, referral and precertification requirements* section.

Genetic care

- Any treatment, device, drug, service or supply to alter the body's genes, genetic make-up, or the

expression of the body's genes except for the correction of congenital birth defects

Growth/Height care

- A treatment, device, drug, service or supply to increase or decrease height or alter the rate of growth
- Surgical procedures, devices and growth hormones to stimulate growth

Hearing aids and exams

The following services or supplies:

- A replacement of:
 - A hearing aid that is lost, stolen or broken
 - A hearing aid installed within the prior 24 month period
- Replacement parts or repairs for a hearing aid
- Batteries or cords
- Cochlear implants
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss
- Any ear or hearing exam performed by a physician who is not certified as an otolaryngologist or otologist
- Hearing exams given during a stay in a hospital or other facility, except those provided to newborns as part of the overall hospital stay
- Any tests, appliances and devices to:
 - Improve your hearing. This includes hearing aid batteries, amplifiers, and auxiliary equipment
 - Enhance other forms of communication to make up for hearing loss or devices that simulate speech

Home health care

- Services for infusion therapy
- Nursing and home health aide services or therapeutic support services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities)
- Transportation
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present
- Homemaker or housekeeper services
- Food or home delivered services
- Maintenance therapy

Hospice care

- Funeral arrangements
- Pastoral counseling
- Respite care
- Bereavement counseling
- Financial or legal counseling which includes estate planning and the drafting of a will
- Homemaker or caretaker services that are services which are not solely related to your care and may include:
 - Sitter or companion services for either you or other family members
 - Transportation
 - Maintenance of the house

Incidental surgeries

- Charges made by a physician for incidental surgeries. These are non-medically necessary surgeries performed during the same procedure as a medically necessary surgery.

Jaw joint disorder

- Surgical treatment of jaw joint disorders
- Non-surgical treatment of jaw joint disorders
- Jaw joint disorders treatment performed by prosthesis placed directly on the teeth, surgical and non-surgical medical and dental services, and diagnostic or therapeutics services related to jaw joint disorders including associated myofascial pain

This exclusion does not apply to covered benefits for treatment of TMJ and CMJ as described in the *Eligible health services under your plan – Temporomandibular joint dysfunction (TMJ) and craniomandibular joint dysfunction (CMJ) treatment* section.

Judgment or settlement

- Services and supplies for the treatment of an injury or illness to the extent that payment is made as a judgment or settlement by any person deemed responsible for the injury or illness (or their insurers)

Mandatory no-fault laws

- Treatment for an injury to the extent benefits are payable under any state no-fault automobile coverage or first party medical benefits payable under any other mandatory no-fault law

Maintenance care

- Care made up of services and supplies that maintain, rather than improve, a level of physical or mental function, except for habilitation therapy services. See the *Eligible health services under your plan – Habilitation therapy services* section

Maternity and related newborn care

- Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries

Medical supplies – outpatient disposable

- Any outpatient disposable supply or device. Examples of these are:
 - Sheaths
 - Bags
 - Elastic garments
 - Support hose
 - Bandages
 - Bedpans
 - Syringes
 - Blood or urine testing supplies
 - Other home test kits
 - Splints
 - Neck braces
 - Compresses
 - Other devices not intended for reuse by another patient

Medicare

- Services and supplies available under Medicare, if you are entitled to premium-free Medicare Part A or enrolled in Medicare Part B, or if you are not entitled to premium-free Medicare Part A or enrolled in Medicare Part B because you refused it, dropped it, or did not make a proper request for it

Mental health and substance abuse related disorders treatment

- The following categories (or equivalent terms as listed in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association) are not covered:
 - Sexual deviations and disorders except for gender identity disorders
 - Tobacco use disorders except as described in the *Eligible health services under your plan – Preventive care and wellness* section
 - Pathological gambling, kleptomania, pyromania
 - Specific developmental disorders of scholastic skills (learning disorders/learning disabilities)
 - Specific developmental disorder of motor functions
 - Specific developmental disorders of speech and language
 - Other disorders of psychological development

Motor vehicle accidents

- Services and supplies given by a provider for injuries sustained from a motor vehicle accident but only when benefits are payable under other valid and collectible insurance. This applies whether or not a claim is made for such benefits.

Non-medically necessary services and supplies

- Services and supplies which are not medically necessary for the diagnosis, care, or treatment of an illness or injury or the restoration of physiological functions. This includes behavioral health services that are not primarily aimed at the treatment of illness, injury, restoration of physiological functions or that do not have a physiological or organic basis. This applies even if they are prescribed, recommended, or approved by your physician, dental provider, or vision care provider. This exception does not apply to *Preventive care and wellness* benefits.

Non-U.S. citizen

- Services and supplies received by a covered person (who is not a United States citizen) within the covered person's home country but only if the home country has a socialized medicine program

Obesity (bariatric) surgery

- Weight management treatment or drugs intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity except as described in the *Eligible health services under your plan – Preventive care and wellness* section, including preventive services for obesity screening and weight management interventions. This is regardless of the existence of other medical conditions. Examples of these are:
 - Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric surgery
 - Surgical procedures, medical treatments and weight control/loss programs primarily intended to treat, or are related to the treatment of obesity, including morbid obesity
 - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications
 - Hypnosis or other forms of therapy
 - Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement

Organ removal

- Services and supplies given by a provider to remove an organ from your body for the purpose of donating or selling the organ except as described in the *Eligible health services under your plan* section. This does not apply if you are donating the organ to a spouse, domestic partner, civil union partner, child, brother, sister, or parent.

Other primary payer

- Payment for a portion of the charge that Medicare or another party is responsible for as the primary payer

Outpatient infusion therapy

- Drugs that are included on the list of specialty prescription drugs as covered under your outpatient prescription drug plan
- Enteral nutrition
- Blood transfusions and blood products
- Dialysis

Outpatient prescription or non-prescription drugs and medicines

- Outpatient prescription drugs or non-prescription drugs and medicines provided by the policyholder
- Drugs that are included on the list of specialty prescription drugs as covered under your outpatient prescription drug plan

Outpatient surgery

- The services of any other physician who helps the operating physician
- A stay in a hospital (Hospital stays are covered in the *Eligible health services under your plan – Hospital and other facility care* section)
- A separate facility charge for surgery performed in a physician's office
- Services of another physician for the administration of a local anesthetic

Pediatric dental care

- Any instruction for diet, plaque control and oral hygiene
- Asynchronous dental treatment
- Cosmetic services and supplies including plastic surgery, reconstructive surgery, cosmetic surgery, personalization or characterization of dentures or other services and supplies which improve alter or enhance appearance, augmentation and vestibuloplasty, and other substances to protect, clean, whiten bleach or alter the appearance of teeth; whether or not for psychological or emotional reasons; except to the extent coverage is specifically provided in the *Eligible health services under your plan* section. Facings on molar crowns and pontics will always be considered cosmetic.
- Crown, inlays, onlays, and veneers unless:
 - It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material or
 - The tooth is an abutment to a covered partial denture or fixed bridge
- Dental implants and braces (that are determined not to be medically necessary mouth guards, and other devices to protect, replace or reposition teeth)
- Dentures, crowns, inlays, onlays, bridges, or other appliances or services used:
 - For splinting
 - To alter vertical dimension
 - To restore occlusion
 - For correcting attrition, abrasion, abfraction or erosion

- Treatment of any jaw joint disorder and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint dysfunction disorder (TMJ) and craniomandibular joint dysfunction disorder (CMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment, except as covered in the *Eligible health services under your plan – Specific conditions* section
- General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another eligible health service
- Mail order and at-home kits for orthodontic treatment
- Orthodontic treatment except as covered in the *Eligible health services under your plan –Pediatric dental care* section
- Pontics, crowns, cast or processed restorations made with high noble metals (gold)
- Prescribed drugs, pre-medication or analgesia (nitrous oxide)
- Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures
- Replacement of teeth beyond the normal complement of 32
- Routine dental exams and other preventive services and supplies, except as specifically provided in the *Eligible health services under your plan —Pediatric dental care* section
- Services and supplies:
 - Done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services
 - Provided for your personal comfort or convenience or the convenience of another person, including a provider
 - Provided in connection with treatment or care that is not covered under your policy
- Surgical removal of impacted wisdom teeth only for orthodontic reasons
- Treatment by other than a dental provider
- Work related: Any **illness** or **injury** related to employment or self-employment including any **injuries** that arise out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the services or supplies. Sources of coverage or reimbursement may include your employer, workers' compensation, or an occupational illness or similar program under local, state or federal law. A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. If you are also covered under a workers' compensation law or similar law, and submit proof that you are not covered for a particular **illness** or injury under such law, that illness or **injury** will be considered "non-occupational" regardless of cause.

Personal care, com fort or convenience items

- Any service or supply primarily for your convenience and personal comfort or that of a third party

Preventive care and wellness

- Services for diagnosis or treatment of a suspected or identified illness or injury
- Exams given during your stay for medical care
- Services not given by or under a physician's direction
- Psychiatric, psychological, personality or emotional testing or exams
- Services provided as a result of complications resulting from a female voluntary sterilization procedure and related follow-up care
- Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA
- Male contraceptive methods or devices
- The reversal of voluntary sterilization procedures, including any related follow-up care
- Female voluntary sterilization procedures that were not billed separately by the provider or were not the primary purpose of a confinement

Private duty nursing (outpatient only)**Prosthetic devices**

- Services covered under any other benefit
- Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes, or if the orthopedic shoe is an integral part of a covered leg brace
- Trusses, corsets, and other support items
- Repair and replacement due to loss, misuse, abuse or theft
- Communication aids
- Cochlear implants

Riot

- Services and supplies that you receive from providers as a result of an injury from your “participation in a riot”. This means when you take part in a riot in any way such as inciting, or conspiring to incite, the riot. It does not include actions that you take in self-defense as long as they are not against people who are trying to restore law and order.

Routine exams

- Routine physical exams, routine eye exams, routine dental exams, routine hearing exams and other preventive services and supplies, except as specifically provided in the *Eligible health services under your plan* section

School health services

- Services and supplies normally provided by the policyholder’s:
 - School health services
 - Infirmary
 - Hospital
 - Pharmacy or

by health professionals who

- Are employed by
- Are Affiliated with
- Have an agreement or arrangement with, or
- Are otherwise designated by

the policyholder.

Services provided by a family member

- Services provided by a spouse, domestic partner, civil union partner parent, child, step-child, brother, sister, in-law or any household member

Sexual dysfunction and enhancement

- Any treatment, prescription drug, service, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
 - Surgery, prescription drugs, implants, devices or preparations to correct or enhance erectile

function, enhance sensitivity, or alter the shape or appearance of a sex organ

- Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services
- Not eligible for coverage are prescription drugs in 60 day supplies

Sinus surgery

- Any services or supplies given by providers for sinus surgery except for acute purulent sinusitis

Sleep apnea

- Any services or supplies given by providers for the treatment of obstructive sleep apnea and sleep disorders

Specialty prescription drugs

- Drugs that are included on the list of specialty prescription drugs as covered under your outpatient prescription drug benefit

Sports

- Any services or supplies given by providers as a result from play or practice of collegiate or intercollegiate sports, not including intercollegiate club sports and intramurals

Strength and performance

- Services, devices and supplies such as drugs or preparations designed primarily for enhancing your:
 - Strength
 - Physical condition
 - Endurance
 - Physical performance

Students in mental health field

- Any services and supplies provided to a covered student who is specializing in the mental health care field and who receives treatment from a provider as part of their training in that field

Telemedicine

- Services given when you are not present at the same time as the provider
- Services including:
 - Telephone calls for behavioral health services
 - Telemedicine kiosks
 - Electronic vital signs monitoring or exchanges, (e.g. Tele-ICU, Tele-stroke)

Temporomandibular joint dysfunction treatment (TMJ) and craniomandibular joint dysfunction treatment (CMJ)

- Dental implants

Therapies and tests

- Full body CT scans
- Hair analysis
- Hypnosis and hypnotherapy
- Massage therapy, except when used as a physical therapy modality
- Sensory or auditory integration therapy

Tobacco cessation

- Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including, medications, nicotine patches and gum unless recommended by the United States Preventive Services Task Force (USPSTF). This also includes:
 - Counseling, except as specifically provided in the *Eligible health services under your plan – Preventive care and wellness* section
 - Hypnosis and other therapies
 - Medications, except as specifically provided in the *Eligible health services under your plan – Outpatient prescription drugs* section
 - Nicotine patches
 - Gum

Transplant services

- Services and supplies furnished to a donor when the recipient is not a covered person
- Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing illness
- Harvesting and/or storage of bone marrow, hematopoietic stem cells, or other blood cells without intending to use them for transplantation within 12 months from harvesting, for an existing illness
- Travel and lodging expenses

Treatment in a federal, state, or governmental entity

- Any care in a hospital or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws

Treatment of infertility

- Injectable **infertility** medication, including but not limited to menotropins, hCG, and GnRH agonists.
- All charges associated with:
 - Surrogacy for you or the surrogate. A surrogate is a female carrying her own genetically related child where the child is conceived with the intention of turning the child over to be raised by others, including the biological father
 - Cryopreservation (freezing) of eggs, embryos or sperm
 - Storage of eggs, embryos, or sperm
 - Thawing of cryopreserved (frozen) eggs, embryos or sperm
 - The care of the donor in a donor egg cycle which includes, but is not limited to, any payments to the donor, donor screening fees, fees for lab tests, and any charges associated with care of the donor required for donor egg retrievals or transfers
 - The use of a gestational carrier for the female acting as the gestational carrier. A gestational carrier is a female carrying an embryo to which the person is not genetically related
 - Obtaining sperm from a person not covered under this plan for ART services
- Home ovulation prediction kits or home pregnancy tests
- The purchase of donor embryos, donor oocytes, or donor sperm
- Reversal of voluntary sterilizations, including follow-up care
- Ovulation induction with menotropins, Intrauterine insemination and any related services, products or procedures
- In vitro fertilization (IVF), Zygote intrafallopian transfer (ZIFT), Gamete intrafallopian transfer (GIFT), Cryopreserved embryo transfers and any related services, products or procedures (such as

Intracytoplasmic sperm injection (ICSI) or ovum microsurgery)

- ART services are not provided for out-of-network care

Vision Care

Pediatric vision care services and supplies

- Office visits to an ophthalmologist, optometrist or optician related to the fitting of prescription contact lenses
- Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes

Adult vision care

- Office visits to an ophthalmologist, optometrist or optician related to the fitting of prescription contact lenses
- Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes

Adult vision care services and supplies

Your plan does not cover adult vision care services and supplies, except as described in the *Eligible health services under your plan – Other services* section.

- Special supplies such as non-prescription sunglasses
- Special vision procedures, such as orthoptics or vision therapy
- Eye exams during your stay in a hospital or other facility for health care
- Eye exams for contact lenses or their fitting
- Eyeglasses or duplicate or spare eyeglasses or lenses or frames
- Replacement of lenses or frames that are lost or stolen or broken
- Acuity tests
- Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures
- Services to treat errors of refraction

Wilderness treatment programs

- Wilderness treatment programs (whether or not the program is part of a residential treatment facility or otherwise licensed institution)
 - Educational services, schooling or any such related or similar program, including therapeutic programs within a school setting

Work related illness or injuries

- Coverage available to you under worker's compensation or under a similar program under local, state or federal law for any illness or injury related to employment or self-employment.
- A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. You may also be covered under a workers' compensation law or similar law. If you submit proof that you are not covered for a particular illness or injury under such law, then that illness or injury will be considered "non-occupational" regardless of cause.

Exclusions that apply to outpatient prescription drugs

Allergy sera and extracts administered via injection

Any services related to the dispensing, injection or application of a drug

Biological sera**Compounded prescriptions**

- Compound prescriptions containing bulk chemicals that have not been approved by the U.S. Food and Drug Administration (FDA) including compounded bioidentical hormones

Cosmetic drugs

- Medications or preparations used for cosmetic purposes

Devices, products and appliances, except those that are specially covered**Dietary supplements** including medical foods**Drugs or medications**

- Administered or entirely consumed at the time and place it is prescribed or dispensed
- Which do not, by federal or state law, require a prescription order (i.e. over-the-counter (OTC) drugs), even if a prescription is written except as specifically provided in the *Eligible health services under your plan – Outpatient prescription drugs* section
- That includes the same active ingredient or a modified version of an active ingredient as a covered prescription drug (unless a medical exception is approved)
- That is therapeutically equivalent or therapeutically alternative to a covered prescription drug including biosimilar (unless a medical exception is approved)
- That is therapeutically equivalent or therapeutically alternative to an over-the-counter (OTC) product (unless a medical exception is approved)
- Not approved by the FDA or not proven safe and effective
- Provided under your medical plan while an inpatient of a healthcare facility
- Recently approved by the U.S. Food and Drug Administration (FDA), but which have not yet been reviewed by Aetna's Pharmacy and Therapeutics Committee
- That includes vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
- For which the cost is covered by a federal, state, or government agency (for example: Medicaid or Veterans Administration)
- That are used to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ
- That are used for the purpose of weight gain or reduction, including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants or other medications
- That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature unless there is evidence that the insured meets one or more clinical criteria detailed in our precertification and clinical policies

Duplicative drug therapy (e.g. two antihistamine drugs)**Genetic care**

- Any treatment, device, drug, service or supply to alter the body's genes, genetic make-up, or the expression of the body's genes except for the correction of congenital birth defects.

Immunizations related to travel or work**Immunization or immunological agents**

Implantable drugs and associated devices except as specifically provided in the *Eligible health services under your plan –Outpatient prescription drugs* sections.

Infertility

- Injectable prescription drugs used primarily for the treatment of infertility.

Injectables

- Any charges for the administration or injection of prescription drugs or injectable insulin and other injectable drugs covered by us
- Needles and syringes, except for those used for self-administration of an injectable drug
- Any drug, which due to its characteristics as determined by us must typically be administered or supervised by a qualified provider or licensed certified health professional in an outpatient setting. This exception does not apply to Depo Provera and other injectable drugs used for contraception.

Insulin pumps or tubing or other ancillary equipment and supplies for insulin pumps except as specifically provided in the *Eligible health services under your plan – Diabetic services and supplies (including equipment and training)* section

Prescription drugs:

- For which there is an over-the-counter (OTC) product which has the same active ingredient and strength even if a prescription is written.
- Packaged in unit dose form.
- Filled prior to the effective date or after the termination date of coverage under this plan.
- Dispensed by a mail order pharmacy that include prescription drugs that cannot be shipped by mail due to state or federal laws or regulations, or when the plan considers shipment through the mail to be unsafe. Examples of these types of drugs include, but are not limited to, narcotics, amphetamines, DEA controlled substances and anticoagulants.
- That include an active metabolite, stereoisomer, prodrug (precursor) or altered formulation of another drug and are not clinically superior to that drug as determined by the plan.
- That are ordered by a dentist or prescribed by an oral surgeon in relation to the removal of teeth, or prescription drugs for the treatment of a dental condition.
- That are considered oral dental preparations and fluoride rinses, except pediatric fluoride tablets or drops as specified on the preferred drug guide.
- That are non-preferred drugs, unless non-preferred drugs are specifically covered as described in your schedule of benefits. However, a non-preferred drug will be covered if in the judgment of the prescriber there is no equivalent prescription drug on the preferred drug guide or the product on the preferred drug guide is ineffective in treating your disease or condition or has caused or is likely to cause an adverse reaction or harm you.
- That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, the use of or intended use of which would be illegal, unethical, imprudent, abusive, not medically necessary, or otherwise improper, and drugs obtained for use by anyone other than the identified on the ID card.

Refills

- Refills dispensed more than one year from the date the latest prescription order was written.

Replacement of lost or stolen prescriptions**Test agents except diabetic test agents****Tobacco cessation**

- Tobacco cessation products unless recommended by the United States Preventive Services Task Force (USPSTF)

We reserve the right to exclude:

- A manufacturer's product when a same or similar drug (that is, a drug with the same active ingredient or same therapeutic effect), supply or equipment is on the preferred drug guide.
- Any dosage or form of a drug when the same drug (that is, a drug with the same active ingredient or same therapeutic effect) is available in a different dosage or form on our preferred drug guide.

Deviations:

1. As per 20/21 Aetna best practice, we cannot administer a separate I/P and O/P Annual Deductible; updated to \$100 for In-Network care.
2. As per 20/21 Aetna best practice, updated UC copay to \$50 in order to adequately incentivize Physician OV.
3. As per 20/21 FL Filing requirements, the following benefits must be covered:
 - a. voluntary sterilization for males
 - b. Allergy Testing and Treatment
 - c. Gender reassignment Treatment