BlueCross BlueShield of Illinois
A Division of Health Care Service Corporation, a Mutual Legal Reserve Company
300 East Randolph Street
Chicago, IL 60601
Or call us at the phone number on the back of your identification card

Rush University

OUTLINE OF COVERAGE

READ YOUR POLICY CAREFULLY – This outline of coverage provides a brief description of the important features of your Policy. This is not the insurance Policy, and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights of both you and Blue Cross and Blue Shield of Illinois. Therefore, it is important that you **READ YOUR POLICY CAREFULLY!**

This Policy is designed to provide you with economic incentives for using designated health care providers. Although you can go to Providers of your choice, your Benefits under this Policy will be greater when you use the services of designated Providers.

Each Benefit Period a Deductible must be satisfied before Benefits will begin, except for Preventive Care Services and other Covered Services not subject to a Deductible. Some Benefits require that a Copayment and/or Coinsurance be paid when services are received. Many of the expenses incurred for Covered Services will also be applied to your Benefit Period Deductible and Out-of-Pocket Maximum. Refer to your Policy for more information.

Changes in some state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

Eligibility for Insurance

Each Covered Person must meet and maintain the eligibility requirements listed below.

Each person in the Class(es) of Eligible Persons shown in the ***Schedule of Benefits*** is eligible to be insured under this Policy. This includes anyone who is eligible on the Policy Effective Date and may become eligible after the Policy Effective Date while the Policy is in force. Students must meet the Institution's requirements for maintaining their status as an eligible Student Home study, correspondence and television (TV) courses do not fulfill the eligibility requirements. Students must maintain their Institution's eligibility in order to maintain coverage under this policy. Covered Students who loses eligibility status prior to the end of their Policy Term will no longer be covered as of the first of the month following the loss of eligibility. Students enrolled for the Summer sessions will not experience a loss in coverage as long as they were covered immediately preceding the Summer sessions. (Students that lose such coverage may be eligible for continuation coverage as provided for in the Policy. Please see Continuation of Coverage section of this Policy.) We maintain the right to investigate Student status and attendance records to verify that eligibility requirements have been met. If We discover the eligibility requirements have not been met, Our only obligation is to refund any unearned premium paid for that person.

CLASS I: ***Domestic Students***

Undergraduate Students who are enrolled in twelve (12) or more credit hours (6 or more for part-time Undergraduate Students) are required to be covered under this Student Health Insurance Plan unless proof of comparable coverage is provided.

Graduate Students who are enrolled in nine (9) or more credit hours (4.5 or more for part-time Graduate Students) are required to be covered under this Student Health Insurance Plan unless proof of comparable coverage is provided.

CLASS II: ***International Students***

Undergraduate Students who are enrolled in twelve (12) or more credit hours are required to be covered under this Student Health Insurance Plan unless proof of comparable coverage is provided.

Graduate Students who are enrolled in nine (9) or more credit hours are required to be covered under this Student Health Insurance Plan unless proof of comparable coverage is provided.

An Insured's Dependent is eligible on the date:

- the Insured is eligible if the Insured has Dependents on that date; or
- the date the person becomes a Dependent of the Insured, if later.

Individuals who are eligible to receive Medicare Benefits are not eligible to enroll in this Plan unless they fall within a Federal exemption.

No eligibility rules or variations in premium will be imposed based on a Student's health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, or any other health status factor. A Student will not be discriminated against for coverage under this Policy on the basis of race, color, national origin, disability, age, sex, gender identity, marital status, sexual orientation, or political affiliation expression. Coverage does not require documentation certifying a COVID-19 vaccination or require documentation of post-transmission recovery as a condition for obtaining coverage or receiving Benefits. Variations in the administration, processes or Benefits of this Policy that are based on clinically indicated, reasonable management practices, or are part of permitted wellness incentives, disincentives and/or other programs do not constitute discrimination.

Effective Date of Coverage

Insurance for an Eligible Student who enrolls during the program's enrollment period, as established by the Institution, is effective on the latest of the following dates:

- the Policy Effective Date;
- the date We receive the completed online enrollment form;
- the date after the required premium is paid; or
- the date the Student enters the Eligible Class.

If coverage for Dependents is offered, coverage for a Student's eligible Dependent who enrolls:

- during the enrollment period established by the Policyholder;
- within 31 days after the Student acquires a new Dependent; or
- within 31 days after a Dependent terminates coverage under another Health Care Plan, is effective on the latest of the following dates:

  (1) the first day of the Policy Term Coverage Period;

  (2) the date the Student enters the Eligible Class;

  (3) the date We receive the completed enrollment form; and

  (4) the date after the required premium is paid.

After the time periods described above, the Student or Dependent must wait until the next enrollment period, except for a newborn or a newly adopted child or if there is an involuntary loss of coverage under another health care plan.

We will pay Benefits for a newborn child of a Covered Person until that child is 31 days old. Coverage may be continued beyond the 31 days if the Covered Person notifies Us of the child's birth and pays the required premium, if any.

Adopted children, as defined by the Policy, will be covered on the same basis as a newborn child from the date the child is placed for adoption with the Insured or the date the Insured becomes a party to a suit for the adoption of the child. Coverage will cease on the date the child is removed from placement and the Insured's legal obligation terminates.

Coverage for newborn and adopted children will consist of coverage for covered Injury or covered Sickness including the necessary care and treatment of medically diagnosed congenital defects, prematurity, well baby care, birth abnormalities, and routine nursery care related with a covered Sickness.

OPEN ENROLLMENT PERIODS

The Institution will designate open enrollment periods, during which Students may apply for or change coverage for himself/herself and/or his/her eligible spouse and/or Dependents.

This section "OPEN ENROLLMENT PERIODS" is subject to change by BCBSIL, and/or Applicable Law or regulatory guidance, as appropriate.

QUALIFYING EVENT

Eligible Students or Dependents who have a change in status and lose coverage under another health care plan are eligible to enroll for coverage under this Policy. Within 31 days of the qualifying event, such Students or Dependents must complete an online qualifying event form and submit a letter of ineligibility. Go to www.bcbsil.com, click on "Shop for Student Health Plans" and select your Institution for more information. A change in status due to a qualifying event includes, but is not limited to, loss of a spouse, whether by death, divorce, annulment, or legal separation, gain of a Dependent whether by birth, adoption, or placement for adoption or court-ordered Dependent coverage, or loss of Dependent status because of age. The premium will either be the same as or prorated based on what it would have been at the beginning of the semester or quarter, whichever applies. However, the Effective Date will be the later of the date the Student enrolls for coverage under this Policy and pays the required premium, or the day after the prior coverage ends. Effective Date of Coverage.

Discontinuance of Insurance

TERMINATION DATE OF INSURANCE

A Student's coverage will end on the earliest of the date:

- the Policy terminates;
- the Student is no longer eligible; or
- the period ends for which premium is paid.

If Coverage is offered for Dependents, a Dependent's coverage will end on the earliest of the date:

- he or she is no longer a Dependent;
- the Student's coverage ends;
- the period ends for which premium is paid; or
- the Policy terminates.

REFUND OF PREMIUM

A refund of premium will be made only in the event:

- of a Covered Person's death; or a Covered Person ceases to maintain eligibility; or
- the Covered Person enters full-time active duty in any Armed Forces; and We receive proof of such active-duty service.

EXTENSION OF BENEFITS

If a Covered Person is confined in a Hospital for a medical condition on the date his or her coverage under this Policy is terminated, expenses incurred during the continuation of that Hospital stay will be considered a Covered Expense, but only while such expenses are incurred during the 90-day period following the termination of insurance. We will not continue to pay these Covered Expenses if:

- the Covered Person's medical condition no longer continues;
- the Covered Person reaches any maximum that may apply;
- the Covered Person obtains other coverage; or
- the Covered Expenses are incurred more than 3 months following termination of insurance.

CONTINUATION OF COVERAGE

A Covered Person who has been insured under the Policy may continue to be insured under the Policy when coverage terminates subject to the following:

- Continuation of Coverage is available to Students and their covered Dependents, when the Student leaves school, dies, or when the covered Dependent no longer qualifies as an eligible Dependent.
- The Covered Person requesting coverage must have been insured under the Policy for at least 3 months.
- Requests for Continuation of Coverage, with the applicable premium, must be mailed to Us, within 30 days of:
  (1) the date the existing coverage would otherwise terminate; or
  (2) the date the Covered Person is notified by Us or the school of the right to continue the coverage.
- Coverage and Benefits will be the same as those which are applicable prior to continuation.
- Premium rates for Continuation of Coverage may be higher than Student rates. Rates, and forms to request Continuation of Coverage, are available from Us.
- The maximum period for which coverage may be continued is 6 months.
- Continuation of Coverage is not available to persons who are eligible for coverage under another health care plan, including Medicare.

Deductibles

Deductible:	In-Network Provider	Out-of-Network Provider
Per Covered Person per Benefit Period:	$500	$1,000
Per Family per Benefit Period	$1,000	$3,000

Out-of-Pocket Maximums

Out-of-Pocket Maximum:	In-Network Provider	Out-of-Network Provider
Per Covered Person per Benefit Period:	$8,550	$15,000
Per Family per Benefit Period	$17,100	$25,400

Preauthorization Penalties

Preauthorization Required	Penalty Amount
Inpatient facility services	**$250**
For Inpatient facility services, the Blue Cross Blue Shield of IL or Host Blue's Participating Provider is required to obtain preauthorization. If preauthorization is not obtained, the Participating Provider will be sanctioned based on the Blue Cross Blue Shield of IL or Host Blue's contractual agreement with the Provider; therefore, the member will be held harmless for the Provider sanction.	

Benefit Highlights for Medical Expenses

Covered Expenses:	In-Network Provider Covered Person Pays:	Out-of-Network Provider* Covered Person Pays:
Inpatient Expenses		
Hospital Expenses	20% of Allowable Amount	50% of Allowable Amount
Surgical Expenses for a Primary Procedure	20% of Allowable Amount	50% of Allowable Amount
- Remaining Eligible Procedure	20% of Allowable Amount	50% of Allowable Amount
- Assistant Surgeon Services	20% of Allowable Amount	50% of Allowable Amount
- Anesthetist Services	20% of Allowable Amount	50% of Allowable Amount
Doctor's Visits	20% of Allowable Amount	50% of Allowable Amount
Outpatient Expenses		
Surgical Expenses for a Primary Procedure	20% of Allowable Amount	50% of Allowable Amount
Remaining Eligible Procedures	20% of Allowable Amount	50% of Allowable Amount
Day Surgery/Outpatient Surgical Expenses	20% of Allowable Amount	50% of Allowable Amount
Day Surgery Miscellaneous Expenses	20% of Allowable Amount	50% of Allowable Amount
- Assistant Surgeon Services	20% of Allowable Amount	50% of Allowable Amount
- Anesthetist Services	20% of Allowable Amount	50% of Allowable Amount
Mental Health Care and Chemical Dependency	20% of Allowable Amount	50% of Allowable Amount

Covered Expenses:	In-Network Provider Covered Person Pays	Out-of-Network Provider * Covered Person Pays
Emergency Room Accidents and Emergency Care (including Accidents, and Emergency and Non-Emergency Care for Behavioral Health Services)		
Facility Charges (excluding Certain Diagnostic Procedures)	20% of Allowable Amount $250 Copayment per visit (waived if admitted to the Hospital as an Inpatient immediately following emergency treatment) Deductible Waived	
- Physician Charges	20% of Allowable Amount	
- Diagnostic X-ray and Laboratory Services	20% of Allowable Amount	50% of Allowable Amount
Non-Emergency Care		
Facility Charges (excluding Certain Diagnostic Procedures)	20% of Allowable Amount $250 Copayment per visit (waived if admitted to the Hospital as an Inpatient immediately following emergency treatment) Deductible Waived	50% of Allowable Amount $500 Copayment per visit (waived if admitted to the Hospital as an Inpatient immediately following emergency treatment)
- Physician Charges	20% of Allowable Amount	50% of Allowable Amount
- Lab and X-ray Charges	20% of Allowable Amount	50% of Allowable Amount
Urgent Care	20% of Allowable Amount After a $50 Copayment	50% of Allowable Amount
Radiation and Chemotherapy Services	20% of Allowable Amount	50% of Allowable Amount
Allergy Injection and Allergy Testing (Copayment may apply if billed in the office)	20% of Allowable Amount	50% of Allowable Amount
Chiropractic and Osteopathic Manipulation Benefits will be limited to 25 visits per Benefit Period	20% of Allowable Amount	50% of Allowable Amount
Office Visits Including Office Visits for Behavioral Health Services	$30 Copayment Deductible Waived	50% of Allowable Amount After a $30 Copayment

Covered Expenses:	In-Network Provider Covered Person Pays	Out-of-Network Provider * Covered Person Pays
Other Expenses		
Additional Surgical Opinion	20% of Allowable Amount	50% of Allowable Amount
Autism Spectrum Disorder	20% of Allowable Amount	50% of Allowable Amount
Durable Medical Equipment	20% of Allowable Amount	50% of Allowable Amount
Orthotic Devices	20% of Allowable Amount	50% of Allowable Amount
Habilitative Services and Devices	20% of Allowable Amount	50% of Allowable Amount
Ground and Air Ambulance Transportation	20% of Allowable Amount	
Routine Well-Baby Care	No Charge	50% of Allowable Amount
Dental Treatment (Injury only to sound, natural teeth)	20% of Allowable Amount	20% of Allowable Amount
Tests and Procedures	20% of Allowable Amount	50% of Allowable Amount
Mental Health Care and Chemical Dependency	20% of Allowable Amount	50% of Allowable Amount
Blood and Blood Components	20% of Allowable Amount	50% of Allowable Amount
Naprapathic Services Benefits will be limited to 15 visits per Benefit Period	20% of Allowable Amount	50% of Allowable Amount
Bariatric Surgery	20% of Allowable Amount	50% of Allowable Amount
Routine Pediatric Hearing Examinations	No Charge	50% of Allowable Amount
Organ and Tissue Transplants	20% of Allowable Amount	50% of Allowable Amount
Injections, when administered in the Doctor's office and charged on the Doctor's statement Deductible Waived	20% of Allowable Amount	50% of Allowable Amount
Abortion Services	20% of Allowable Amount	50% of Allowable Amount
Extended Care Expenses		
Skilled Nursing Facility No Benefit Period Visit Maximum	20% of Allowable Amount	50% of Allowable Amount
Coordinated Home Health Care No Benefit Period Visit Maximum	20% of Allowable Amount	50% of Allowable Amount

Covered Expenses:	In-Network Provider Covered Person Pays	Out-of-Network Provider * Covered Person Pays
Hospice Services No Benefit Period Visit Maximum	20% of Allowable Amount	50% of Allowable Amount
Cardiac Rehabilitation Services Benefits will be limited to 36 visits per Benefit Period	20% of Allowable Amount	50% of Allowable Amount
Private Duty Nursing Services No Benefit Period Visit Maximum	20% of Allowable Amount	50% of Allowable Amount
Pulmonary Rehabilitation Therapy	20% of Allowable Amount	50% of Allowable Amount
Needlestick – Only for Students doing course work or Hospital training	No Charge Deductible Waived	

Benefit Highlights for Outpatient Prescription Drugs

Copayments for Outpatient Prescription Drugs*:	Preferred Participating and Participating Pharmacies
Preferred Generic Drugs and diabetic supplies, insulin, and insulin syringes	$20 per prescription
Non-Preferred Generic Drugs and diabetic supplies, insulin, and insulin syringes	$20 per prescription
Preferred Brand Name Drugs and diabetic supplies, insulin, and insulin syringes	$50 per prescription, plus the cost difference between the Generic and Brand Name Drug or diabetic supplies per prescription
Non-Preferred Brand Name Drugs and diabetic supplies, insulin, and insulin syringes for which there is a Generic Drug or supply available	$80 per prescription, plus the cost difference between the Generic and Brand Name Drug or diabetic supplies per prescription
Preferred Specialty Drugs	$20/$50 per prescription
Non-Preferred Specialty Drugs	$20/$80 per prescription

*One prescription means up to a 30 consecutive day supply of a drug (except for certain drugs).
Covered Persons can purchase a 90-day supply for 3 times the amount indicated above.

Covered Persons will be responsible for the difference between the amount paid by us under this Policy and the billed charges when receiving Prescription Drugs from a Non-Participating Pharmacy.

Non-Participating Pharmacies: When a Covered Person obtains Prescription Drugs, including diabetic supplies from a Non-Participating Pharmacy (other than a Participating Pharmacy), Benefits will be provided at 50% of the amount a Covered Person would have received had he/she obtained drugs from a Participating Pharmacy minus the Copayment amount or Coinsurance amount and will not apply to a Covered Person's Deductible.

Specialty Drugs: In order to receive maximum Benefits for Specialty Drugs, a Covered Person must obtain the Specialty Drugs from a preferred Specialty Pharmacy Provider. Specialty Drugs obtained from all other pharmacies will be provided at 50% of the amount a Covered Person would have received had he/she obtained drugs from a Specialty Pharmacy Provider and will not apply to a Covered Person's Deductible.

Schedule of Pediatric Vision Coverage
For Covered Persons Under Age 19

Vision Care Services	In-Network Cost or Discount When a Copayment is due from the Covered Person, the remainder due is paidby this Policy, up to the covered charge *	Out-of-Network Reimbursement This is the maximum amount payable under this Policy, not to exceed the retailcost.
Exam (with dilation as necessary)	No Copayment	Up to $30
Routine eye exams do not include professional services for contact lens evaluations. Any applicable fees are the responsibility of the patient.		
Frames		
Provider Designated frames	No Copayment	Up to $75
Non-Provider Designated frames	$150 allowance on Non-Provider designated frame, 20% off balanceover $150	Not Covered
Lenses Standard Plastic, Glass, or Poly Spectacle Lenses		
Single Vision	No Copayment	Up to $25
Bifocal	No Copayment	Up to $40
Trifocal	No Copayment	Up to $55
Lenticular	No Copayment	Up to $55
Standard Progressive Lens	No Copayment	Up to $55
Premium Progressive Lens – Tier 1	$20 Copayment	Not Covered
Premium Progressive Lens – Tier 2	$30 Copayment	Not Covered
Premium Progressive Lens – Tier 3	$45 Copayment	Not Covered
Premium Progressive Lens – Tier 4	No Copayment $120 allowance, 20% off balance over $120	Not Covered

Vision Care Services	In-Network Cost or Discount When a Copayment is due from the Covered Person, the remainder due is paid by this Policy, up to the covered charge *	Out-of-Network Reimbursement This is the maximum amount payable under this Policy, not to exceed the retail cost.
Lens Options – in addition to lens prices above		
UV Treatment	No Copayment	Up to $12
Tint (Fashion, Gradient, and Glass-Grey)	No Copayment	Up to $12
Standard Plastic Scratch Coating	No Copayment	Up to $12
Standard Polycarbonate	No Copayment	Up to $32
Standard Anti-Reflective Coating	$45 Copayment	Not Covered
Premium Anti-Reflective Coating Tier 1	$57 Copayment	Not Covered
Premium Anti-Reflective Coating Tier 2	$68 Copayment	Not Covered
Premium Anti-Reflective Coating Tier 3	20% off Retail Price	Not Covered
Polarized	20% off Retail Price	Not Covered
Glass	No Copayment	Up to $12
Photochromic/Transition Plastic	No Copayment	Up to $57
Oversized	No Copayment	Not Covered
Other Add-ons	20% off Retail Price	Not Covered
Contact Lenses – materials only		
Provider Designated Contact Lenses – No Copayment, covered 100% per supply listed below		
Extended Wear Disposables	Up to 6-month supply of monthly, or2-week disposable, single vision spherical or toric Contact Lenses	Up to $150
Daily Wear Disposables	Up to 3-month supply of daily disposable, single vision spherical Contact Lenses	Up to $150
Conventional	1 pair from selection of Provider Designated Contact Lenses	Up to $150
Medically Necessary Contact Lenses	No Copayment	Up to $210

Note: *In some instances, participating Providers may charge separately for the evaluation, fitting, or follow-up care relating to Contact Lenses. Should this occur, and the value of the contact lenses received is less than the allowance, a Covered Person may submit a Claim for the remaining balance (the combined reimbursement will not exceed the total allowance.*

Value-added features:

Laser vision correction: 15% off Retail Price, or 5% off promotional price.

Mail-order contact lens replacement: www.contactsdirect.com.

Value-Added Features *– In-Network Providers may offer discounted prices for non-covered lenses. Discounted prices may vary by state and are subject to change or discontinuance at any time without notice. THE DISCOUNTS ARE NOT INSURANCE.*

Additional Benefits:

Medically Necessary Contact Lenses: Contact Lenses maybe determined to be Medically Necessary and appropriate in the treatment of patients affected by certain conditions. In general, Contact Lenses maybe Medically Necessary and appropriate when the use of Contact Lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. Contact Lenses may be determined to be Medically Necessary in the treatment of the following conditions:

Keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders, irregular astigmatism.

Medically Necessary Contact Lenses are covered in lieu of other eyewear.

Low Vision: Low vision is a significant loss of vision but not total blindness. Ophthalmologists and Optometrists specializing in low vision care evaluate and prescribe optical devices and provide training and instruction to maximize the remaining usable vision for Our Covered Person with low vision.

Covered Persons who require low-vision services and optical devices are entitled to the following coverage, both In and Out-of-Network:

Low Vision Evaluation: One comprehensive evaluation every five years. This examination, sometimes called a functional vision assessment, can determine distance and clarity of vision, the size of readable print, the existence of blind spots or tunnel vision, depth perception, eye-hand coordination, problems, perceiving contrast and lightning requirements for optimum vision.

Low-Vision Aid: Covered for one device per year such as high-power spectacles, magnifiers, and telescopes. These devices are utilized to maximize use of available vision, reduce problems of glare, or increase contract perception, based on the individual's visual goals and lifestyle needs.

Follow-up care: Four visits in any five-year period.

Warranty: Warranty limitations may apply to Provider or retailer supplied frames and/or eyeglass lenses. Covered Persons should ask their Provider for details of the warranty that is available to them.

*The covered charge is the rate negotiated with Network Providers for a particular Covered Service.

In an Out-of-Network Benefit Offering and Non-Provider Designated frames: Frames covered by this Policy are limited to the Provider Designated frames. The Network Provider will show you the selection of frames covered by this Policy. If you select a frame that is not included in the Provider Designated frames covered under this Policy, you are responsible for the difference in cost between the Network Provider reimbursement amount for covered Provider Designated frames and the retail price of the frame selected. If frames are provided by an Out-of-Network Provider, Benefits are limited to the amount shown above in the ***Schedule of Benefits*. Any amount: (1) paid to the Network Provider for the difference in cost of a Non-Provider Designated frame; or (2) that exceeds the Maximum Covered Fee for an Out-of-Network Provider supplied frame will not apply to any applicable Deductible, Coinsurance, or Out-of-Pocket Maximum/Out-of-Pocket limit/Out-of-Pocket Coinsurance maximum.

EXCLUSIONS AND LIMITATIONS

Except as specified in this Policy, coverage is not provided for loss or charges incurred by or resulting from:

1. Charges that are not Medically Necessary or in excess of the Allowable Amount;
2. Services that are provided, normally without charge, by the Student Health Center, infirmary or Hospital, or by any person employed by the University;
3. Acupuncture procedures;
4. Bio-feedback procedures;
5. Breast augmentation or reduction;
6. Routine circumcision, unless the procedure is Medically Necessary for treatment of a Sickness, disease or functional Congenital Disorder not excluded hereunder or as may be necessitated due to an Accident or except for covered infants within 28 days of birth;
7. Any charges for Surgery, procedures, treatment, facilities, supplies, devices, or drugs that the Insurer determines are Experimental or Investigational, except as specifically mentioned in this Policy;
8. Expenses incurred for Injury or Sickness arising out of or in the course of a Covered Person's employment, regardless of if benefits are, or could be paid or payable under any Worker's Compensation or Occupational Disease Law or Act, or similar legislation;
9. Treatment, services or supplies in a Veteran's Administration or Hospital owned or operated by a national government or its agencies unless there is a legal obligation for the Covered Person to pay for the treatment;
10. Blood derivatives which are not classified as drugs in the official formularies;
11. Expenses in connection with services and prescriptions for eye examinations, eye refractions, eyeglasses or contact lenses, or the fitting of eyeglasses or contact lenses radial keratotomy or laser Surgery for vision correction or the treatment of visual defects or problems, except for pediatric vision;
12. Cosmetic Surgery and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors or diseases;
13. Riding as a passenger or otherwise in any vehicle or device for aerial navigation except as a fare paying passenger in an aircraft operated by a commercial scheduled airline;
14. Injury resulting from racing or speed contests, skin diving, sky diving, parachuting, hang gliding, glider flying, parasailing, sail planing, bungee jumping, mountaineering (where ropes or guides are customarily used), or any other hazardous sport or hobby;
15. War, or any act of war, whether declared or undeclared or while in service in the active or reserve Armed Forces of any country or international authority;
16. Any expenses incurred in connection with connection with sexual dysfunction, sterilization reversal or vasectomy removal;
17. Expenses incurred for dental care or treatment of the teeth, gums or structures directly supporting the teeth, including surgical extractions of teeth. This exclusion does not apply to the repair of Injuries to sound natural teeth caused by a covered Injury;
18. Hirsutism;
19. Alopecia;
20. Gynecomastia;
21. Surgery for the removal of excess skin or fat;
22. Fluids, solutions, nutrients, or medications (including all additives and Chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion or by intravenous, intramuscular (in the muscle), intrathecal (in the spine), or intraarticular (in the joint) injection in the home setting, except as specifically mentioned in this Policy. NOTE: This exception does not apply to dietary formula necessary for the treatment of phenylketonuria (PKU) or other inheritable diseases;
23. Custodial Care Service;
24. Long Term Care Service;
25. Inpatient Private Duty Nursing Service;
26. Habilitative Services that are solely educational in nature or otherwise paid under State or Federal law for purely educational services;

27. Notwithstanding any provision in this Policy to the contrary, any services and/or supplies provided to a Covered Person outside the United States, unless a Covered Persons receives Emergency Care.
28. Services and supplies from more than one Provider on the same day(s) to the extent benefits are duplicated;
29. Benefits will not be provided for any self-administered drugs dispensed by a Physician;
30. Behavioral health services provided at behavioral modification facilities, boot camps, emotional group academies, military schools, therapeutic boarding schools, wilderness programs, halfway houses and group homes, except for Covered Services provided by appropriate Providers as defined in this Policy;
31. Any related services to a non-covered service except for routine patient care for participants in an Approved Clinical Trial. Related services are:
    - Services in preparation for the non-covered service;
    - Services in connection with providing the non-covered service;
    - Hospitalization required to perform the non-covered service; or
    - Services that are usually provided following the non-covered service, such as follow up care or therapy after surgery;
32. Any of the following applied behavior analysis (ABA) related services:
    - Services with a primary diagnosis that is not Autism Spectrum Disorder;
    - Services that are facilitated by a Provider that is not properly credentialed (Please see the definition of "Qualified ABA Provider" in the Definitions Section of this Policy);
    - Activities primarily of an educational nature;
    - Shadow or companion services; or
    - Any other services not provided by an appropriately licensed Behavioral Health Practitioner in accordance with nationally accepted treatment standards;
33. Experimental/Investigational Services and Supplies and all related services and supplies, except as may be provided under this Policy for:
    - Routine Patient Costs associated with Experimental/Investigational cancer treatment, if you are a qualified individual participating in a qualified clinical cancer trial, if those services or supplies would otherwise be covered under this Policy if not provided in connection with a qualified cancer trial program; and
    - Applied behavior analysis used for the treatment of Autism Spectrum Disorder(s).
34. Respite Care Service, except as specifically mentioned under the Hospice Care Program section of this Policy;
35. Services or supplies received during an Inpatient stay when the stay is solely related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Illness. This does not include services or supplies provided for the treatment of an injury resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions);
36. Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage;
37. Charges for failure to keep a scheduled visit, or charges for completion of a Claim form;
38. Personal hygiene, comfort or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions and telephones;
39. Special braces, specialized equipment, appliances, ambulatory apparatus, except as specifically mentioned in this Policy;
40. Immunizations, unless otherwise specified in this Policy;
41. Maintenance Occupational Therapy, Maintenance Physical Therapy and Maintenance Speech Therapy, except as specifically mentioned in this Policy;
42. Maintenance Care;
43. Diagnostic Service as part of determination of the refractive errors of the eyes, auditory problems, surveys, case finding, research studies, screening, or similar procedures and studies, or tests which are Experimental/Investigational, unless otherwise specified in this Policy;
44. Procurement or use of prosthetic devices, special appliances and surgical implants which are for cosmetic purposes, for the comfort and convenience of the patient, or unrelated to the treatment of a disease or injury;
45. Wigs (also referred to as cranial prostheses) unless otherwise specified in this Policy;
46. Charges for medication, drugs or hormones to stimulate growth;

47. Repair and replacement for appliances and/or devices due to misuse or loss, except as specifically mentioned in this Policy.

Prescription Drug coverage is not provided for:

1. Drugs which are not included on the Drug List unless specifically covered elsewhere in this Policy and/or such coverage is required in accordance with applicable law or regulatory guidance;
2. Drugs which do not by law require a Prescription Order from a Provider or Health Care Practitioner (except insulin, insulin analogs, insulin pens, and prescriptive and non-prescriptive oral agents for controlling blood sugar levels, and vaccinations administered through certain Participating Pharmacies); and drugs or covered devices for which no valid Prescription Order is obtained;
3. Drugs dispensed in quantities in excess of the day supply amounts stipulated in this benefit section, certain Covered Drugs exceeding the clinically appropriate predetermined quantity, or refills of any prescriptions in excess of the number of refills specified by the Physician or Health Care Practitioner or by law, or any drugs or medicines dispensed in excess of the amount or beyond the time period allowed by law;
4. Drugs labeled "Caution - limited by federal law to investigational use" or experimental drugs;
5. Administration of injection of any drugs;
6. Vitamins (except those vitamins which by law require a Prescription Order and for which there is not non–prescription alternative);
7. Covered Drugs, devices, or other Pharmacy services or supplies provided or available in connection with an occupational sickness or an injury sustained in the scope of and in the course of employment whether benefits are, or could upon proper claim be, provided under the Workers' Compensation law;
8. Any special services provided by the Pharmacy, including but not limited to, counseling and delivery. Vaccinations administered through certain Participating Pharmacies are an exception to this exclusion;
9. Drugs dispensed in a Physician's or Health Care Practitioner's office or during confinement while as a patient in a Hospital, or other acute care institution or facility, including take-home drugs or samples; and drugs dispensed by a nursing home or custodial or chronic care institution or facility;
10. Drugs, that the use or intended use of which would be illegal, abusive, not Medically Necessary;
11. Drugs obtained by unauthorized, fraudulent, abusive or improper use of the Identification Card;
12. Drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction, which is not covered under your Policy, or for which benefits have been exhausted;
13. Prescription Orders for which there is an over-the-counter product available with the same active ingredient(s) in the same strength, unless otherwise determined;
14. Athletic performance enhancement drugs;
15. Lost or stolen prescriptions;
16. Compound medications;
17. Drugs determined by the Plan to have inferior efficacy or significant safety issues;
18. Pharmaceutical aids such as excipients found in the USP-NF (United States Pharmacopeia- National Formulary), including, but not limited to preservatives, solvents, ointment bases, and flavoring coloring diluting emulsifying and suspending agents;
19. Institutional packs and drugs which are repackaged by anyone other than the original manufacturer;
20. Bulk Powders;
21. Diagnostic agents (except for diabetic testing supplies or test strips);
22. Male condoms;
23. Drugs that are not considered Medically Necessary or treatment recommendations that are not supported by evidence-based guidelines or clinical practice guidelines;
24. Medications in depot or long-acting formulations that are intended for use longer than the covered days' supply amount;
25. Certain drug classes where there are over-the-counter alternatives available.