Schedule of Benefits
My**Priority** HSA℠

PPO High Deductible Health Plan (HDHP)
(HSA Compatible)

100% Network — 50% Non-Network

Your Policy provides you with important information about your health care benefits, including prior approval requirements and your Coverage level choices. You may obtain medical services from a Network Provider and receive a higher level of benefits (the Network Benefits level), or you may obtain services from a Non-Network Provider and have coverage under the Non-Network Benefits level.

This Schedule of Benefits provides you with information about your costs at both benefit levels when you receive health care services and the maximum limitations of your health care benefits. Read the entire Policy, Schedule of Benefits and any Plan Addenda carefully.

In accordance with the terms and conditions of the Policy, you are entitled to Covered Services when these services are:

A. Medically/Clinically Necessary (as defined in the Policy and according to Medical and Behavioral Health policies established by Priority Health with the input of physicians not employed by Priority Health or according to criteria developed by reputable external sources and adopted by Priority Health); and

B. Not excluded in the Policy or in an Addendum or an Amendment to the Policy.

See Section 5 of your Policy for Covered and Non-Covered Services, including the summary of Covered Preventive Health Care Services. Priority Health's complete preventive health care guidelines are available in our Member Center on our website at *priorityhealth.com*, or you may request a copy from our Customer Service Department.

PRE-EXISTING CONDITION EXCLUSION
(This provision does not apply to anyone under the age of 19.)

Benefits will be excluded for each Illness or Injury or condition not disclosed on your application, for which, during the six month period prior to your effective date, medical advice, diagnosis, care or treatment was recommended by or received from a Health Professional. For purposes of this limitation, "treatment" includes the use of prescription drugs. Genetic information is not treated as a Pre-Existing Condition in the absence of a diagnosis of a condition related to the genetic information.

This Pre-Existing Condition exclusion will apply until the end of the twelve-month period beginning on your effective date under this Policy. The Pre-Existing Condition exclusion does not apply to anyone under the age of 19.

BENEFIT WAITING PERIODS

Certain surgeries and the treatment of certain conditions are excluded from Coverage during your first 90 consecutive days of Coverage under the Policy, beginning with your most recent effective date. Surgeries subject to the 90 day waiting period include: Tonsillectomy, Adenoidectomy, Hemorrhoidectomy, Hysterectomy and Bunionectomy, Surgical treatment of the following conditions are also subject to the 90 day waiting period: Cystocele, Enterocele, Rectocele, Urethrocele, Uterine Prolapse, Inguinal Hernia (other than strangulated or incarcerated), Carpal Tunnel Syndrome and Varicose Veins.

PRIOR APPROVAL

Prior approval is required before you may obtain certain services. If you seek services that require prior approval, without receiving prior approval from us, your benefits will be reduced for those services. You will also be responsible for those services that are beyond those approved, beyond the benefit maximums or excluded from Coverage.

You or your physician must call (800) 269-1260 to obtain prior approval for services. Emergency admissions must be reported to us as soon as reasonably possible after admission.

DEDUCTIBLE AND OUT-OF-POCKET MAXIMUMS

A. Deductibles:

The Deductible is the amount you must pay for Covered Services during the Contract Year before benefits will be paid. Your Deductible will also take into account any monies paid under your prescription drug benefits.

The Network Benefits Deductible is applicable to all Covered Services except Preventive Health Care Services designated to maintain an individual in optimum health and to prevent unnecessary injury, illness or disability. See Section 5 of your Policy for Covered and Non-Covered Services, including the summary of Covered Preventive Health Care Services. Priority Health's complete preventive health care guidelines are available in our Member Center on our website at *priorityhealth.com*, or you may request a copy from our Customer Service Department.

Prenatal and pregnancy services are not Covered under the Policy.

The Non-Network Benefit Deductible is applicable to Covered Services received under the Non-Network Benefit level or received from Non-Network Providers.

The Deductibles renew each Contract Year. Deductible amounts do not carry over into a new Contract Year.

Individual Contract and Family Contract Deductibles:

- If you are the only individual on your contract, you have a Subscriber Only Contract and the Subscriber Only Contract Deductible applies.
- If you have more than one individual on your contract, you have a Subscriber Plus Dependent(s) Contract and only the Subscriber Plus Dependent(s) Deductible applies. The Subscriber Plus Dependent(s) Contract Deductible can be satisfied by any one family member or by any combination of family members.

Notwithstanding the above, the following out-of-pocket Member costs do not apply towards the Deductibles:

- any monies you paid for Non-Covered Services; and
- any monies you paid for Covered Services that exceed the annual day, visit or dollar benefit maximum for a specific benefit and therefore, denied as non-Covered Services; and
- any reduction in payment for failure to preauthorize services; and
- any monies you paid to providers for Non-Network Benefits that exceed Reasonable and Customary; and
- any monies you paid for Covered Services because the combined Network Benefits and Non-Network Benefits Maximum Annual Benefit per Member per Contract year is exhausted; and

The Network and Non-Network Deductibles are calculated separately. Network and Non-Network Deductible amounts you pay, are included in the applicable Out-of-Pocket Maximums.

Deductibles	Network Benefits	Non-Network Benefits
Subscriber Only Contract	$2,000.00	$4,000.00
Subscriber Plus Dependent(s) Contract	$4,000.00	$8,000.00

B. Non-Network Benefits Out-of-Pocket Maximums:

The Non-Network Benefits Out-of-Pocket Maximum limits the total amount that you will pay toward Covered Services under the Non-Network Benefits level during a Contract Year. Once the applicable Out-of-Pocket Maximum for the Non-Network Benefits level is met, all further Covered Services for that Contract Year for Non-Network Benefits will be paid at 100% of the lesser of billed charges or Reasonable and Customary Charges.

If you have an Individual Contract, when calculating your Out-of-Pocket Maximum, we will include all Copayments, Coinsurance and Deductibles you paid toward Covered Services during a Contract Year. If you have a Family Contract, we will include all Copayments, Coinsurance and Deductibles you and your family paid collectively toward Covered Services during a Contract Year.

Out-of-Pocket Maximums	Network Benefits	Non-Network Benefits
Subscriber Only Contract	$2,000.00	$ 9,000.00
Subscriber Plus Dependent(s) Contract	$4,000.00	$18,000.00

Notwithstanding the above, amounts paid for any of the following will <u>not</u> apply toward the Non-Network Benefits Out-of-Pocket Maximum:

- any reduction in benefits for failure to obtain prior approval when necessary
- any monies you paid for non-Covered Services
- any monies you paid for Covered Services that exceed the annual day/visit or dollar benefit maximum for a specific benefit and therefore, denied as non-Covered Services
- any monies you paid to providers for Non-Network Benefits that exceed Reasonable and Customary
- any monies you paid for Covered Services because the combined Network Benefits and Non-Network Benefits Maximum Annual Benefit per Member per Contract year is exhausted

The Out-of-Pocket Maximum limits the total amount of covered expenses that you or your dependents will pay during a Contract Year. Once the applicable Out-of-Pocket Maximum for the Network benefits level is met, all further medical Covered Services for that Contract Year for Network Benefits will be paid at 100% of Priority Health's contracted rate. Once the applicable Out-of-Pocket Maximum for the Non-Network Benefits level is met, all further medical Covered Services for the Contract Year for Non-Network Benefits will be paid at 100% of the lesser of billed charges or Reasonable and Customary Charges.

Note: If the reduction in benefits for failure to obtain prior approval applies, the amount Priority Health pays will be reduced even if the Non-Network Benefits Out-of-Pocket Maximum has been reached.

C. Maximum Annual Benefit Per Member:

$2,000,000.00 is the combined Maximum Annual Benefit per Member for all Network and Non-Network Covered Services per Contract Year*.

$1,000,000.00 is the maximum annual transplant benefit per Member for all Covered transplants per Contract Year. This amount is included in and part of the Maximum Annual Benefit per Member described in the paragraph above.

Covered Benefits

Benefits	Network Benefits	Non-Network Benefits**
Preventive Health Services (See Section 5.IV.A.1 of your Policy for the summary of Covered Preventive Health Care Services) ***Note:*** Pre-natal and pregnancy services are not Covered under the Policy.	• 100% Coverage • Deductible waived	**Not Covered**
PHYSICIAN SERVICES		
Office Visits and Urgent Care Visits Visits for Sickness, Injury, or follow-up (face-to-face, telephonic, or through secure electronic portal) ***Note:*** Pre-natal and pregnancy services are not Covered under the Policy.	100% Coverage. Deductible applies.	50% Coverage of Reasonable and Customary Charges. Deductible applies.
Inpatient Hospital Visits	100% Coverage. Deductible applies.	50% Coverage of Reasonable and Customary Charges. Deductible applies.
Surgery	100% Coverage. Deductible applies.	50% Coverage of Reasonable and Customary Charges. Deductible applies.
Ambulatory Surgery Center Services	100% Coverage. Deductible applies.	50% Coverage of Reasonable and Customary Charges. Deductible applies.

Benefits	Network Benefits	Non-Network Benefits**
Allergy Testing and Serum	100% Coverage. Deductible applies.	50% Coverage of Reasonable and Customary Charges. Deductible applies.
Allergy Injections	100% Coverage. Deductible applies.	50% Coverage of Reasonable and Customary Charges. Deductible applies.
Maternity Services (Prenatal delivery and postnatal) **Note:** Complications of a Pregnancy, as defined in Section 16 of the Policy, are Covered subject to the terms and conditions of the Policy.	**Not Covered** (including Physicians' fees and any other related charges)	**Not Covered** (including Physicians' fees and any other related charges)
Family Planning	**Not Covered** (including Physicians' fees and any other related charges)	**Not Covered** (including Physicians' fees and any other related charges)
Infertility Services	**Not Covered** (including Physicians' fees and any other related charges)	**Not Covered** (including Physicians' fees and any other related charges)
Tubal Ligation	**Not Covered** (including Physicians' fees and any other related charges)	**Not Covered** (including Physicians' fees and any other related charges)
Vasectomy	**Not Covered** (including Physicians' fees and any other related charges)	**Not Covered** (including Physicians' fees and any other related charges)
Temporomandibular Joint Dysfunction or Syndrome	**Not Covered** (including Physicians' fees and any other related charges)	**Not Covered** (including Physicians' fees and any other related charges)
Orthognathic Surgery	**Not Covered** (including Physicians' fees and any other related charges)	**Not Covered** (including Physicians' fees and any other related charges)

Benefits	Network Benefits	Non-Network Benefits**
Certain Surgeries and Treatments • Reconstructive surgeries o Blepharoplasty o Breast reduction o Panniculectomy o Rhinoplasty o Septorhinoplasty o Surgical treatment of male gynecomastia • Skin disorder treatments o Scar revision o Keloid scar treatment o Treatment of hyperhidrosis o Excision of lipomas o Excision of seborrheic keratoses o Excision of skin tags o Treatment of vitiligo o Port wine stain and hemangioma treatment • Sleep apnea treatment procedures	**Not Covered** (including Physicians' fees and any other related charges)	**Not Covered** (including Physicians' fees and any other related charges)
Treatment of Morbid Obesity • Weight loss programs • Bariatric surgery	**Not Covered** (including Physicians' fees and any other related charges)	**Not Covered** (including Physicians' fees and any other related charges)
Transplants	100% Coverage to a $1,000,000.00 maximum annual transplant benefit per Member per Contract Year. This amount is included in and part of the Maximum Annual Benefit per Member under this Policy. Deductible applies. .	**Not Covered** (including Physicians' fees and any other related charges)

Benefits	Network Benefits	Non-Network Benefits**
HOSPITAL SERVICES (Including radiology examinations and laboratory services)		
Inpatient Hospital and Inpatient Longterm Acute Care Services (Including observation care, transplants and maternity stays for a mother and her Newborn of up to 96 hours following a Medically/Clinically Necessary cesarean section) Prenatal and pregnancy services are not Covered under this Policy.	• 100% Coverage • Prior approval required at least five working days in advance, except in emergencies or for hospital stays for a mother and her Newborn of up to 96 hours following a Medically/Clinically Necessary cesarean section. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Notification required for admissions following emergency room care • Deductible applies	• 60% Coverage of Reasonable and Customary Charges • Prior approval required at least five working days in advance, except in emergencies or for hospital stays for a mother and her Newborn of up to 96 hours following a cesarean section. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Notification required for admissions following emergency room care • Deductible applies
Outpatient Hospital Services (Including ambulatory surgery center facility charges)	• 100% Coverage • Some services may require prior approval, including certain radiology examinations • Deductible applies	• 50% Coverage of Reasonable and Customary Charges • Some services may require prior approval, including certain radiology examinations • Deductible applies
MEDICAL EMERGENCY SERVICES		
Emergency Room Services (Non-emergency use of the emergency room is not Covered)	100% Coverage. Deductible applies.	100% Coverage. Deductible applies.
Urgent Care Facility Services	See **Office Visits and Urgent Care Visits** category under PHYSICIAN SERVICES section of this Schedule of Benefits	See **Office Visits and Urgent Care Visits** category under PHYSICIAN SERVICES section of this Schedule of Benefits
Ambulance Services (air or ground)	100% Coverage. Deductible applies.	100% Coverage. Deductible applies.

Benefits	Network Benefits	Non-Network Benefits**
BEHAVIORAL HEALTH SERVICES		
Mental Health Inpatient (including partial hospitalization)	**Not Covered** (including Physicians' fees and any other related charges)	**Not Covered** (including Physicians' fees and any other related charges)
Mental Health Outpatient	**Not Covered** (including Physicians' fees and any other related charges)	**Not Covered** (including Physicians' fees and any other related charges)
Substance Abuse Care (Including subacute, intermediate care, and outpatient evaluation/therapy)	• 100% Coverage • Except in an emergency, prior approval required for subacute and partial hospitalization services. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies	• 50% Coverage of Reasonable and Customary Charges • Except in an emergency, prior approval required for subacute and partial hospitalization services. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies
REHABILITATIVE MEDICINE SERVICES		
Rehabilitative Medicine Services Outpatient Physical Therapy, Occupational Therapy, Speech Therapy, Cardiac Rehabilitation, Pulmonary Rehabilitation, Osteopathic Manipulations and Chiropractic Spinal Manipulations	• 100% Coverage up to a combined benefit maximum of 30 visits per Contract Year* • Deductible applies.	• 50% Coverage of Reasonable and Customary Charges up to a combined benefit maximum of 30 visits per Contract Year*. • Deductible applies

Benefits	Network Benefits	Non-Network Benefits**
OTHER SERVICES		
Radiology Examinations and Laboratory Procedures - Includes services *not* Covered under Preventive Health Care Services	• 100% Coverage • High-tech imaging services require prior approval. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies	• 50% Coverage of Reasonable and Customary Charges • High-tech imaging services require prior approval. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies
Durable Medical Equipment (rent, purchase or repair)**; and Prosthetic and Orthotic/Support Devices**	• 100% Coverage up to a combined benefit maximum of $2,000.00 per Member per Contract Year* • Prior approval required for devices over $1,000.00 • Deductible applies	• 50% Coverage of Reasonable and Customary Charges up to a combined benefit maximum of $2,000.00 per Member per Contract Year* • Prior approval required for devices over $1,000.00 • Deductible applies
Non-Acute Hospital Facility Services • Skilled Nursing Facility • Subacute Facility • Inpatient Rehabilitation Facility • Hospice Facility	• 100% Coverage up to the combined benefit maximum of 60 days per Contract Year* • Prior approval required. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies	• 50% Coverage of Reasonable and Customary Charges up to the combined benefit maximum of 60 days per Contract Year* • Prior approval required. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies
Home Health Care (Including hospice care in the home, excluding Rehabilitative Medicine) **Note:** Rehabilitative services provided in the home are subject to the limitations of the Rehabilitative Medicine Services benefits described above.	• 100% Coverage up to the combined benefit maximum of 60 days per Contract Year* • Prior approval required except for hospice services in the home. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies	• 50% Coverage of Reasonable and Customary Charges up to the combined benefit maximum of 60 days per Contract Year* • Prior approval required except for hospice services in the home. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies
Dietician Services - Includes visits *not* Covered under Preventive Health Care Services	• 100% Coverage to a maximum benefit of 6 visits per Member per Contract Year* • Deductible applies	**Not Covered**

MEDICAL PLAN PHARMACY SERVICES

In general, Covered drugs are treated as medical benefits when administered in an inpatient or emergency setting, or when the drug requires injection or infusion by a Health Professional. Exceptions to this rule are outlined in our medical policies.

The Deductible will apply to Covered medical plan pharmacy services that are detailed below.

Medication Formulary - A list of both Generic and Brand Name Drugs, including Specialty Drugs, approved by Priority Health Pharmacy and Therapeutics Committee for use by our Members. Preferred Brand Name Drugs are usually Brand Name Drugs that have been on the market for a while or are commonly prescribed and have been selected based on their clinical effectiveness and safety. Non-preferred Brand Name Drugs are usually the highest cost drugs in a given category that have lower-cost alternatives with equal or better clinical effectiveness.

Specialty Drug - Drugs listed on the Medication Formulary meeting certain criteria, such as:

- drugs or drug classes whose cost on a per- month or per-dose basis exceeds the threshold established by the Centers for Medicare and Medicaid Services; or
- drugs that require special handling or administration; or
- drugs that have limited distribution; or
- drugs in selected therapeutic categories.

Specialty Pharmacy - A Pharmacy that specializes in the handling, distribution, and patient management of Specialty Drugs.

Benefits	Network Benefits	Non-Network Benefits
Drugs Requiring Administration by a Health Professional (injectable and infusible drugs requiring administration by a Health Professional in a medical office, home or outpatient facility)	• 100% Coverage • Deductible applies • Prior approval required. Step therapy may be required before drugs will be Covered. • Priority Health may require selected Specialty Drugs be obtained by your provider through a Specialty Pharmacy	• 50% Coverage to a maximum benefit of $25,000.00 per Member per Contract Year • Deductible applies • Amounts paid after Deductible do apply toward Out-of-Pocket Maximums • Prior approval required. Step therapy may be required before drugs will be Covered. • Priority Health may require selected Specialty Drugs be obtained by your provider through a Specialty Pharmacy

PRESCRIPTION DRUG BENEFITS - RETAIL PHARMACY		
Benefits	**Network Benefits**	**Non-Network Benefits**
Retail Pharmacy Services (prescription drugs obtained at a retail Network Pharmacy dispensed in a 31-day supply per prescription or refill or through our mail order service dispensed in a 90-day supply per prescription or refill) In general, Covered retail pharmacy drugs are treated as outpatient prescription drug benefits when they can be self-administered regardless of the setting. Exceptions to this rule are outlined in our medical policies. **Note:** If you elect to receive a Brand Name Drug when the prescription allows a Generic Drug substitution, you may be responsible for difference in cost between the Generic Drug and the Brand Name Drug. Prior approval or step therapy may be required. ***Note:*** Certain drugs are Covered under Preventive Health Care Services and not your prescription drug benefits. **For more information, see OUTPATIENT PRESCRIPTION DRUGS benefit description at the end of this Schedule of Benefits document.**	• 100% Coverage for a Generic or Brand Name Drug on our Medication Formulary. Limitations and exclusions apply. • Deductible applies • Self-administered injectable drugs must be obtained at a Network Pharmacy (including Participating Specialty Pharmacies for selected drug categories) • Priority Health may require selected Specialty Drugs be obtained by your provider through a Specialty Pharmacy	**Not Covered** **Exception**: Prescription drugs dispensed by a Non-Network Pharmacy during a Medical Emergency or Urgent Care situation will be Covered under the Retail Pharmacy Services Network Benefits level

MAXIMUM LIMITATIONS

* **Benefit Maximums:** Benefit maximums up to a certain number of days/visits per Contract Year are reached by combining either Network or Non-Network Benefits up to the limit for one or the other, but not both. (Example: If Network Benefits is for 60 visits and Non-Network Benefits is for 60 visits, the maximum benefit is 60 visits, not 120.) Benefit maximums apply even when continued care is Medically/Clinically Necessary beyond the benefit maximum.

** **Reasonable and Customary Charge – Non-Network Benefits:** Your Non-Network Benefits will be calculated using the lower of billed charges or Reasonable and Customary Charges for such service(s). See your Policy for details.

OUTPATIENT PRESCRIPTION DRUGS – RETAIL PHARMACY

Generic and Brand Name Drugs Plan

Covered Services

In general, Covered drugs are treated as outpatient prescription drug benefits when they are obtained at a retail Pharmacy and can be self-administered regardless of the setting. Exceptions to this rule are outlined in our medical policies.

Prescription drugs Coverage is subject to the Deductibles, Copayments and Coinsurance as well as any maximum benefit outlined in this Schedule of Benefits to the Policy.

Coverage is based on the usage of our Medication Formulary, which is a list of both generic and brand name drugs approved by Priority Health physicians and pharmacists for use by our Members. Drugs are added to, or removed from, the Medication Formulary on a regular basis. Some drugs require prior authorization, including off-label use of Food and Drug Administration approved drugs, and Coverage may be approved upon review by us. We will cover outpatient prescription drugs that:

(a) require a prescription order written by a Physician,

(b) are dispensed by a Network Pharmacy, including our designated mail order pharmacy, and

(c) are listed in our Medication Formulary. (Limitations and exclusions to the Medication Formulary apply. See *Non-Covered Services* in this section below.)

We reserve the right to require the use of generic equivalents when available and in accordance with state law governing drug product selection. We require the use of specific specialty pharmacies for certain drugs, including selected injectable drugs. We will not Cover prescription drugs for which Coverage is excluded. See *Non-Covered Services* in this section below.

If a Physician prescribes a non-Formulary drug, that drug may be Covered, if approved upon review by us. Priority Health will provide notice of its determination regarding an exception for a non-Formulary drug within 24 hours of receiving all information necessary to make the determination.

We will Cover outpatient prescription drugs dispensed by a Non-Network Pharmacy during a Medical Emergency or Urgent Care situation.

Covered outpatient prescription drugs include some or all of the following:

- Federal legend drugs - medicinal substances available only through prescription.
- State-restricted drugs - medicinal substances which, according to state law, may only be dispensed by prescription.
- Compounded medications - medicinal substances compounded by the pharmacist which have at least one ingredient that is federal legend or state-restricted in a therapeutic amount.
- Injectable insulin and disposable syringes and needles for administration of injectable insulin; nonexperimental medication for controlling blood sugar; and medication used in the treatment of ailments, infections or medical conditions of the foot, ankle or nails associated with diabetes. (Note: Diabetic supplies such as syringes, needles, lancets, and blood glucose test strips, can be purchased at a Network Pharmacy and your prescription drug Copayment or Coinsurance will apply. These supplies can also be purchased at a Network or Non-Network Durable Medical Equipment (DME) provider and your DME Copayment or Coinsurance will apply as listed in the Schedule of Benefits.)
- Selected injectable drugs in certain categories, such as arthritis injections, growth hormone injections, hepatitis C injections, migraine injections and multiple sclerosis injections, which are self-administered or administered in a medical office or outpatient facility by a Health Professional. Some injectable drugs require prior authorization from Priority Health. Information on Covered injectable drugs is available from our Customer Service Department or on our website at *priorityhealth.com.*

- Oral contraceptives (birth control pills), even if for a medical condition other than birth control.

If you elect to receive a Brand Name Drug when an equivalent Generic Drug is reasonably available, you may be responsible for the difference in cost between the Brand Name Drug and the Generic Drug.

Determination of whether a drug is labeled as a generic or a brand name will be made by First Databank, the leading national electronic drug database for determining pricing and categories of drugs. A compound drug is considered to be a brand name drug.

Non-Covered Services

- Except for drugs listed in Preventive Health Care Services, drugs which do not, by federal or state law, require a prescription order (over-the-counter (OTC) drugs). **Note:** We may elect to include certain OTC drugs on the Medication Formulary, based on recommendations made by our Pharmacy and Therapeutics Committee.
- Any legend drugs for which an over-the-counter (OTC) equivalent is available without a prescription order, such as Lotrimin.
- Any non-sedating antihistamine (NSA), such as Zyrtec.
- Any proton pump inhibitor (PPI), such as Prilosec OTC.
- Schedule V controlled substances available without a prescription order.
- Therapeutic or testing devices, appliances, and medical supplies, support garments and other non-prescription supplies or substances regardless of their intended use.
- Injectable drugs not listed in the *Covered Services* sections of this Pharmacy Services category.
- Syringes, needles or disposable supplies, other than disposable syringes and needles prescribed with injectable insulin.
- Any charges for the administration of prescribed legend drugs or injectable insulin.
- Cosmetics or any drugs used for cosmetic purposes (such as, for example, drugs for the treatment of wrinkles, hair loss, medication to treat fungal discoloration of nails, and health or beauty aids).
- Testing reagents, insulin pumps and tubing for insulin pumps.
- Drugs used primarily to treat mental health disorders.
- Drugs for the treatment of sexual dysfunction, regardless of age, gender or health status.
- Drugs for the treatment of infertility.
- Non-oral methods of contraceptive management, even if administered by a Physician or dispensed by a Pharmacy, such as transdermal and implantable contraceptives; diaphragms and IUD's (including measurement); and condoms, foams, jellies or ointments and other drugs or devices available over the counter.
- Drugs for smoking cessation except for drugs listed in Preventive Health Care Services.
- Multivitamins (including prenatal vitamins) and nutritional supplements, except when these are the only means of nutrition.
- Drugs used for the purpose of weight reduction (such as, for example, appetite suppressants) except for drugs listed in Preventive Health Care Services.
- Any medication prescribed in a manner other than in accordance with our procedures.
- Prescription drugs for procedures and services that are not Covered Services, except for anti-rejection drugs in connection with organ transplants which are Covered.
- Any medication which is consumed or administered at the place where it is dispensed.
- Replacement of lost or damaged prescriptions.

- Drugs for which no charge is made to the recipient.
- Any drug labeled "Caution: Limited by Federal Law to Investigational Use," and any experimental drugs.
- Drugs not approved by the Food and Drug Administration (FDA) under the Federal Food, Drug and Cosmetic Law and regulations.
- Prescription orders filled before your effective date or after your termination date of the Coverage under this Policy.
- Refills in excess of the amount specified by the prescriber, and any refill dispensed after one year from the order of the prescriber.
- Specialty drugs in excess of a 31-day supply.

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