



BlueCross BlueShield of Oklahoma

1215 South Boulder • P. O. Box 3283 • Tulsa, OK 74102-3283

Simply Blue

OUTLINE OF COVERAGE

READ YOUR POLICY CAREFULLY – This outline of coverage provides only a very brief description of the important features of your Contract. This is not the insurance contract, and only the actual Contract provisions will control. The Contract itself sets forth in detail the rights and obligations of both you and Blue Cross and Blue Shield of Oklahoma. Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

Simply Blue coverage is designed to provide you with economic incentives for using participating health care providers.

It provides, to persons insured, coverage for Comprehensive Health Care Services incurred as a result of a covered accident or illness. Coverage is subject to any Copayment, Deductible and Coinsurance provisions, or other limitations and exclusions which may be set forth in the Contract.

Although you can go to any Provider of your choice, your Benefits under the Simply Blue Contract will be greater when you use the services of Providers participating in the BlueChoice PPO or BlueCard PPO networks.

The first premium must be paid with the application. Subsequent premiums are due by the premium due date specified in the member billing notice.

Simply Blue coverage will continue in force at your option. However, Blue Cross and Blue Shield of Oklahoma may non-renew or discontinue coverage for you and your Dependents for the following reasons:

- non-payment of premiums;
- fraud;
- termination of the particular type of coverage, or all coverage, in the individual market; or
- movement of you and/or your Dependents outside the Plan’s service area.

COMPREHENSIVE HEALTH CARE SERVICES	
Benefits for Covered Services are based upon the Allowable Charge. Consult the Contract for definitions and your financial responsibility.	
BENEFIT PERIOD/POLICY YEAR	Calendar Year
OFFICE VISIT COPAYMENT	<p>\$40 for each visit to the Physician's or other Provider's office. The Copayment applies to charges which are billed as part of your Physician's office visit, except for:</p> <ul style="list-style-type: none"> • Preventive Care Services received from a BlueChoice PPO or BlueCard Provider; • Annual mammography screening; • Covered childhood immunizations (for Subscribers under age 19); • Surgical services; • Diagnostic Services (except for Preventive Care Services received from a BlueChoice PPO or BlueCard Provider); • Physical Therapy and Occupational Therapy; • Chemotherapy; • Allergy testing and allergy injections; • Prescription Drugs and related services; • Durable Medical Equipment, prosthetic appliances or orthotic devices.

COMPREHENSIVE HEALTH CARE SERVICES (CONTINUED)

OFFICE VISIT COPAYMENT (CONTINUED)	The Copayment does not count toward the Deductible or Stop-Loss Limit under the Contract. In addition, the Copayment will continue to apply to charges Incurred after the Deductible and/or Stop-Loss Limit has been reached.
DEDUCTIBLE	
Emergency Room Deductible	\$200 for each visit to a Hospital emergency room. This Deductible is waived if you are admitted to the Hospital through the emergency room visit.
Outpatient Surgery Deductible	\$200 for each visit to an Outpatient facility for Surgery. This Deductible applies to surgical procedures received in a Hospital Outpatient department or Ambulatory Surgical Facility.
Hospital Admission Deductible	\$500 for each visit to a Hospital. This Deductible applies to Covered Services Incurred during the Subscriber's admission to a Hospital except for Routine Nursery Care.
Benefit Period Deductible	<ul style="list-style-type: none"> • \$1,000 – \$10,000 per Benefit Period per Subscriber for Covered Services received from BlueChoice PPO Providers or BlueCard Providers. • \$2,000 – \$20,000 per Benefit Period per Subscriber for Covered Services received from Out-of-Network Providers. <p>These Deductible amounts cross-apply. Any services you receive from BlueChoice PPO, BlueCard or Out-of-Network Providers will count toward both Deductible amounts shown above. However, the higher Deductible amount will apply whenever you receive services from a Provider who is not in the BlueChoice PPO or BlueCard Provider networks.</p> <p>The Benefit Period Deductible is in addition to the emergency room Deductible, Outpatient Surgery Deductible and Hospital Admission Deductible described above.</p> <p>The Benefit Period Deductible applies to all Covered Services, except:</p> <ul style="list-style-type: none"> • Routine Nursery Care; • Prescription Drugs and related services; • BlueChoice PPO or BlueCard Physician services that are subject to the office visit Copayment. • Preventive Care Services received from a BluePreferred, BlueChoice, BlueTraditional or BlueCard Provider. Preventive Care Services received from an Out-of-Network Provider are subject to Deductible, except for: <ul style="list-style-type: none"> – Annual routine gynecological/obstetrical examination and Pap smear; – Annual mammography screening; – Annual prostate cancer screening; – Covered childhood immunizations (for Subscribers under age 19); – Any other state or federally mandated Benefits which stipulate Deductible may not be required.

COMPREHENSIVE HEALTH CARE SERVICES (CONTINUED)

<p>FAMILY DEDUCTIBLE</p>	<p>If your coverage includes your Dependents, then:</p> <ul style="list-style-type: none"> • no more than three times the individual Deductible must be satisfied in each Benefit Period for all family members covered under your membership; and • if two or more Subscribers under your membership incur expenses for Covered Services as a result of injuries received in the same accident, only one Deductible will be applied to the aggregate of such charges. <p>No family Subscriber will contribute more than the individual Deductible amount.</p> <p>The Family Benefit Period Deductible provisions described above do not include the emergency room Deductible, Outpatient Surgery Deductible or Hospital Admission Deductible.</p>
<p>STOP-LOSS LIMIT</p>	<p>When you have Incurred \$10,000 <i>in excess of any</i> Deductible amount for Covered Services during a Benefit Period, the amount of Allowable Charges covered by the Plan on your behalf will increase to 100% during the remainder of the Benefit Period. This Stop-Loss Limit does not apply to expenses Incurred for Outpatient Prescription Drugs.</p> <p>This Stop-Loss Limit does not include any of the following:</p> <ul style="list-style-type: none"> • Services, supplies or charges limited or excluded by this Contract; • Expenses not covered because a Benefit maximum has been reached; • Any Deductible amount set forth in this Contract; • Any Copayment amounts Incurred for <i>Comprehensive Health Care Services</i> or <i>Outpatient Prescription Drugs</i>; • Any amounts Incurred under the <i>Outpatient Prescription Drug Benefits</i> section; • Any penalty Incurred due to your failure to follow the Plan’s guidelines for Preauthorization, as set forth in this Contract.
<p>LIFETIME BENEFIT MAXIMUM</p>	<p>Unlimited.</p>
<p>BENEFIT PERCENTAGE AMOUNT</p>	<p>The following chart shows the percentage of Allowable Charges covered by your Simply Blue Contract through payments and/or contractual arrangements with Providers. These percentages apply only after your Deductible, Copayment and/or Coinsurance amounts have been satisfied.</p>

COVERED SERVICES (See <i>Comprehensive Health Care Services</i> section of Contract)	BENEFIT PERCENTAGE AMOUNT	
	BlueChoice PPO & BlueCard PPO Provider Services	Out-of-Network Provider Services
PREVENTIVE CARE SERVICES		
Annual Mammography Screening	100%	100%
Covered Childhood Immunizations	100%	100%
All Other Covered Preventive Care Services	100%	70%
EMERGENCY CARE SERVICES	70%	70%
THE FOLLOWING BENEFIT PERCENTAGES APPLY TO SERVICES THAT ARE NOT CLASSIFIED AS PREVENTIVE CARE SERVICES OR EMERGENCY CARE SERVICES, AS DETERMINED BY THE PLAN		
HOSPITAL SERVICES¹	70%	50%
SURGICAL/MEDICAL SERVICES		
Physician Office Visits	100% ²	70%
All Other Covered Surgical/Medical Services	70%	50%
OUTPATIENT DIAGNOSTIC SERVICES	70%	50%
OUTPATIENT THERAPY SERVICES	70%	50%
Maximum of 25 Outpatient visits for Physical Therapy and Occupational Therapy (combined) per Benefit Period		
SERVICES RELATED TO COMPLICATIONS OF PREGNANCY³	70%	50%
MASTECTOMY AND RECONSTRUCTIVE SURGICAL SERVICES	70%	50%
HUMAN ORGAN, TISSUE AND BONE MARROW TRANSPLANT SERVICES⁴	70%	50%
AMBULATORY SURGICAL FACILITY SERVICES	70%	50%
AMBULANCE SERVICES	70%	70%
PRIVATE DUTY NURSING SERVICES⁴	70%	50%
85 visit maximum per Benefit Period		
REHABILITATION CARE⁴	70%	50%
30 day maximum per Benefit Period		

¹ Inpatient Hospital Services are subject to Preauthorization approval from the Plan. See the Contract for details regarding Preauthorization requirements.

² Applicable only to Covered Services which are subject to the office visit Copayment. For services which are not subject to the office visit Copayment, this percentage amount is reduced to 70% of Allowable Charges after satisfaction of the Deductible.

³ All other Maternity Services are excluded.

⁴ Subject to Preauthorization approval from the Plan. See the Contract for details regarding Preauthorization requirements.

	BENEFIT PERCENTAGE AMOUNT									
COVERED SERVICES (See <i>Comprehensive Health Care Services</i> section of Contract)	<u>BlueChoice PPO & BlueCard PPO Provider Services</u>	<u>Out-of-Network Provider Services</u>								
SKILLED NURSING FACILITY SERVICES¹ 30 day maximum per Benefit Period	70%	50%								
HOME HEALTH CARE SERVICES¹ 30 visit maximum per Benefit Period	70%	50%								
HOSPICE SERVICES¹	70%	50%								
DENTAL SERVICES FOR ACCIDENTAL INJURY	70%	50%								
DIABETES EQUIPMENT, SUPPLIES AND SELF-MANAGEMENT SERVICES	70%	50%								
DURABLE MEDICAL EQUIPMENT	70%	50%								
PROSTHETIC APPLIANCES	70%	50%								
ORTHOTIC DEVICES \$2,500 maximum per Benefit Period	70%	50%								
WIGS OR OTHER SCALP PROSTHESES \$150 maximum per Benefit Period	70%	50%								
ALL OTHER COVERED SERVICES	70%	50%								
OUTPATIENT PRESCRIPTION DRUGS										
BENEFIT PERIOD	Calendar Year									
COPAYMENT/COINSURANCE	The Copayment/Coinsurance applicable to each Prescription Order is set forth below:									
Generic Drugs	<p>\$10 Copayment</p> <p>The Copayment will be applied as follows:</p> <table border="0"> <thead> <tr> <th><u>Quantity Dispensed</u></th> <th><u>Number of Copayments</u></th> </tr> </thead> <tbody> <tr> <td>1 to 30 days</td> <td>1 Copayment</td> </tr> <tr> <td>31 to 60 days²</td> <td>2 Copayments</td> </tr> <tr> <td>61 to 90 days¹</td> <td>3 Copayments</td> </tr> </tbody> </table>		<u>Quantity Dispensed</u>	<u>Number of Copayments</u>	1 to 30 days	1 Copayment	31 to 60 days ²	2 Copayments	61 to 90 days ¹	3 Copayments
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1 to 30 days	1 Copayment									
31 to 60 days ²	2 Copayments									
61 to 90 days ¹	3 Copayments									
Preferred Drugs	<p>50% of Allowable Charge</p> <p>If your Prescription Order is filled by an Out-of-Network Pharmacy, you will be responsible for 50% Coinsurance, <i>plus the difference</i>, if any, between the Pharmacy's billed charges and the Allowable Charge determined by the Plan.</p>									
Non-Preferred Brand Drugs	<p>You are responsible for the entire cost of Non-Preferred Brand Drugs. However, if you use a Participating Pharmacy to fill your Prescription Order, you will be entitled to the negotiated discount applicable to all Blue Cross and Blue Shield of Oklahoma Subscribers.</p>									

¹ Subject to Preauthorization approval from the Plan. See the Contract for details regarding Preauthorization requirements.

² Maintenance drugs only.

PREEXISTING CONDITION LIMITATION

Benefits will not be provided for a Preexisting Condition, or for charges relating to a Preexisting Condition, until the date the Subscriber's coverage has been in effect for 12 consecutive months. A condition or complication thereof is considered "preexisting" if any of the following events occurred within 12 months before the Subscriber's Effective Date:

- Medical expenses were Incurred; or
- Medical advice or diagnosis was given; or
- Medication was taken or prescribed; or
- Treatment was recommended by or received from a Physician or other Provider; or
- The Subscriber had an awareness of symptoms.

COVERAGE EXCLUSION RIDER

A Subscriber's coverage under the Contract may be subject to a "Coverage Exclusion Rider," which is issued at the time the Subscriber's membership is accepted by the Plan. When a Subscriber is enrolled with a Coverage Exclusion Rider, this means that Benefits will not be provided for any expenses incurred which relate to any condition(s) listed on the Coverage Exclusion Rider. Unlike a Preexisting Condition Limitation, the Coverage Exclusion Rider does not end once the Subscriber has been enrolled for 12 months. The Coverage Exclusion Rider will remain in force and effect until the Subscriber's coverage terminates, or until the Coverage Exclusion Rider is released in writing by the Plan.

EXCLUSIONS

- Which are not prescribed by or performed by or upon the direction of a Physician or other Provider.
 - Which we determine are not Medically Necessary, except as specified.
 - Received from other than a Provider.
 - Which are in excess of the Allowable Charge, as determined by the Plan.
 - Which the Plan determines are Experimental/Investigational in nature.
 - For any illness or injury occurring in the course of employment if whole or partial compensation or benefits are or might have been available under the laws of any governmental unit; any policy of workers' compensation insurance; or according to any recognized legal remedy arising from an employer-employee relationship. This applies whether or not you claim the benefits or compensation or recover the losses from a third party.
 - You agree to:
 - pursue your rights under the workers' compensation laws;
 - take no action prejudicing the rights and interests of the Plan; and
 - cooperate and furnish information and assistance the Plan requires to help enforce its rights.
 - If you receive any money in settlement of your employer's liability, regardless of whether the settlement includes a provision for payment of your medical bills, you agree to:
 - hold the money in trust for the benefit of the Plan to the extent that the Plan has paid any Benefits or would be obligated to pay any Benefits; and
 - repay the Plan any money recovered from your employer or insurance carrier.
 - To the extent payment has been made under Medicare or would have been made if you had applied for Medicare and claimed Medicare benefits, or to the extent governmental units provide benefits (some state or federal laws may affect how we apply this exclusion).
 - For any illness or injury suffered after the Subscriber's Effective Date as a result of war or any act of war, declared or undeclared, when serving in the military or any auxiliary unit thereto.
 - For which you have no legal obligation to pay in the absence of this or like coverage.
 - Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar person or group.
 - For cosmetic Surgery or complications resulting therefrom, including Surgery to improve or restore your appearance, unless:
 - needed to repair conditions resulting from an accidental injury; or
 - for the improvement of the physiological functioning of a malformed body member, except for services related to Orthognathic Surgery, osteotomy, or any other form of oral Surgery, dentistry, or dental processes to the teeth and surrounding tissue.
- In no event will any care and services for breast reconstruction or implantation or removal of breast prostheses be a Covered Service unless such care and services are performed solely and directly as a result of mastectomy which is Medically Necessary.

EXCLUSIONS (CONTINUED)

- Received from a member of your immediate family.
- Received before your Effective Date.
- For any Inpatient care and services, including rehabilitation care and services, unless documentation can be provided that, due to the nature of the services rendered or your condition, you cannot receive safe or adequate care as an Outpatient.
- Received after your coverage stops.
- For personal hygiene and convenience items regardless of whether or not recommended by a Physician or other Provider. Examples include: computers; air conditioners, air purifiers or filters; humidifiers; or physical fitness equipment, including exercise bicycles or treadmills; or modifications to your home or vehicle.
- For telephone consultations, email or other electronic consultations, missed appointments, or completion of a claim form.
- For Custodial Care such as sitters' or homemakers' services, care in a place that serves you primarily as a residence when you do not require skilled nursing, or for rest cures.
- For foot care only to improve comfort or appearance such as care for flat feet, subluxation, corns, bunions (except capsular and bone Surgery), calluses, toenails, and the like.
- For routine, screening or periodic physical examinations, except as specified in the *Comprehensive Health Care Services* section of the Contract.
- For Maternity Services, except for Complications of Pregnancy.
- For reverse sterilization.
- For contraceptive medications or devices which are sold without a prescription from a Physician or other Provider (including condoms; contraceptive foam, sponges, or cream; or other spermicides).
- For Orthognathic Surgery, osteotomy, or any other form of oral Surgery, dentistry, or dental processes to the teeth and surrounding tissue (including complications resulting therefrom), except for:
 - the treatment of accidental injury to the jaw, sound natural teeth, mouth or face; or
 - for the improvement of the physiological functioning of a malformed body member.Benefits are not provided for dental implants, grafting of alveolar ridges, or for any complications arising from such procedures.
- For or related to Inpatient treatment of any non-covered dental procedure, except that coverage shall be provided for Hospital Services, Ambulatory Surgical Facility Services, and anesthesia services associated with any Medically Necessary dental procedure when provided to a Subscriber who is:
 - severely disabled; or
 - eight years of age or under;and who has a medical or emotional condition which requires hospitalization or general anesthesia for dental care.
- For eyeglasses, contact lenses or examinations for prescribing or fitting them, except for aphakic patients (including lenses required after cataract Surgery) and soft lenses or sclera shells to treat disease or injury. Vision examinations not related to the prescription or fitting of lenses will be a Covered Service only when performed in connection with the diagnosis or treatment of disease or injury, or as specified under "Preventive Care Services." Eye refractions are not covered in any event.
- For eye Surgery such as radial keratotomy, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring).
- For hearing aids, tinnitus maskers, or examinations for prescribing or fitting them, except as specified for Subscribers under age 18. Hearing examinations not related to the prescription or fitting of hearing aids will be a Covered Service only when performed in connection with the diagnosis or treatment of disease or injury, or as specified under "Preventive Care Services."
- For Speech Therapy and any related diagnostic testing, except as provided by a Hospital or rehabilitation facility as part of a covered Inpatient stay.
- For transsexual Surgery or any treatment leading to or in connection with transsexual Surgery.
- For diagnosis, treatment or medications for infertility and fertilization procedures. Examples include any form of: artificial insemination; ovulation induction procedures; in vitro fertilization; embryo transfer; or any other procedures, supplies or medications which in any way are intended to augment or enhance your reproductive ability.
- For treatment of sexual problems not caused by organic disease.
- For treatment of obesity, including morbid obesity, regardless of the patient's history or diagnosis, including but not limited to the following: weight reduction or dietary control programs; surgical procedures; prescription or nonprescription drugs or medications such as vitamins (whether to be taken orally or by injection), minerals, appetite suppressants, or nutritional supplements; and any complications resulting from weight loss treatments or procedures.
- For smoking cessation programs or medications, including Prescription Drugs.

EXCLUSIONS (CONTINUED)

- For medication, drugs or hormones to stimulate growth.
- For or related to acupuncture, whether for medical or anesthesia purposes.
- For treatment related to Mental Illness, substance abuse or chemical dependency.
- For conditions related to autistic disease of childhood, hyperkinetic syndromes, learning disabilities, behavioral problems, mental retardation, or for Inpatient confinement for environmental change. This exclusion **shall not** apply to the following Medically Necessary services:
 - Services from a Physician or other Provider (except for neuropsychological testing) related to the diagnosis and treatment of attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD) for Subscribers age 19 and under; or
 - Prescription Drug therapy for treatment of ADD/ADHD in Subscribers age 19 and under.
- For family or marital counseling.
- For hippotherapy, equine assisted learning, or other therapeutic riding programs.
- For which the Provider of service customarily makes no direct charge to a Subscriber.
- For treatment of temporomandibular joint dysfunction, including but not limited to diagnostic procedures, splints, orthodontic/orthopedic appliances, restorations necessary to increase vertical dimension or to restore or maintain functional or centric occlusion, alteration of teeth or jaws, Physical Therapy, and medication and behavioral modification related to conditions of temporomandibular joint syndrome or any other conditions involving the jaw joint, adjacent muscles or nerves, regardless of cause or diagnosis.
- For or related to transplantation of donor organs, tissues or bone marrow, except as specified under "Human Organ, Tissue and Bone Marrow Transplant Services."
- For Physician standby services.
- For Continuous Passive Motion (CPM) devices used in treatment of the shoulder or other joints, except for up to 21 days postoperatively for the following surgical procedures: total knee arthroplasty, anterior cruciate ligament reconstruction, or open reduction and internal fixation of tibial plateau for distal femur fractures involving the knee joint.
- For ductal lavage of the mammary ducts.
- For extracorporeal shock wave treatment, also known as orthotripsy, using either a high-or low-dose protocol, for treatment of plantar fasciitis and all other musculoskeletal conditions.
- For orthoptic training.
- For thermal capsulorrhaphy as a treatment of joint instability, including but not limited to instability of shoulders, knees and elbows.
- For transcutaneous electrical nerve stimulator (TENS).
- For massage therapy, including but not limited to effleurage, petrissage and/or tapotement.
- For services rendered by midwives.
- Which are not specifically named as Covered Services subject to any other specific Exclusions and limitations in your Contract.

ADDITIONAL EXCLUSIONS APPLICABLE TO OUTPATIENT PRESCRIPTION DRUGS

In addition to the exclusions and limitations specified above, no Benefits will be provided under the ***Outpatient Prescription Drug Benefits*** section for:

- Drugs which by law do not require a Prescription Order from an authorized Provider (except insulin, insulin analogs, insulin pens, and prescriptive and nonprescriptive oral agents for controlling blood sugar level); and drugs, insulin or covered devices for which no valid Prescription Order is obtained.
- Devices or Durable Medical Equipment of any type (even though such devices may require a Prescription Order), such as, but not limited to, contraceptive devices, therapeutic devices, artificial appliances, or similar devices (**except** disposable hypodermic needles and syringes for self-administered injections.) However, coverage for prescription contraceptive devices is provided under the ***Comprehensive Health Care Services*** section of the Contract.
- Administration or injection of any drugs (except for vaccines administered by a Participating Pharmacy).
- Vitamins (**except** those vitamins which by law require a Prescription Order and for which there is **no** non-prescription alternative).
- Drugs dispensed in a Physician's office or during confinement while a patient in a Hospital, or other acute care institution or facility, including take-home drugs; and drugs dispensed by a nursing home or custodial or chronic care institution or facility.

ADDITIONAL EXCLUSIONS APPLICABLE TO OUTPATIENT PRESCRIPTION DRUGS (CONTINUED)

- Covered Drugs, devices, or other Pharmacy services or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States (including but not limited to, any services or supplies for which benefits are payable under Part A and Part B of Title XVIII of the Social Security Act (Medicare), or the laws, regulations or established procedures of any county or municipality, except any program which is a state plan for medical assistance (Medicaid), or any Prescription Drug which may be properly obtained without charge under local, state, or federal programs, unless such exclusion is expressly prohibited by law; provided, however, that this exclusion shall not be applicable to any coverage held by the Member for prescription drug expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.
- Any services provided or items furnished for which the Pharmacy normally does not charge.
- Covered Drugs for which the Pharmacy's usual and customary charge to the general public is less than or equal to the Coinsurance amount or Copayment amount provided under the Contract.
- Infertility medications and fertility medications; prescription contraceptive devices or non-prescription contraceptive materials (**except** oral contraceptive medications which are Prescription Drugs). However, coverage for prescription contraceptive devices is provided under the *Comprehensive Health Care Services* section of the Contract.
- Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations.
- Drugs required by law to be labeled: "Caution — Limited by Federal Law to Investigational Use," or Experimental drugs, even though a charge is made for the drugs.
- Covered Drugs dispensed in quantities in excess of the amounts stipulated in this *Outpatient Prescription Drug Benefits* section; or refills of any prescriptions in excess of the number of refills specified by the Physician or by law; or any drugs or medicines dispensed more than one year following the Prescription Order date.
- Drugs which are not approved by the U.S. Food and Drug Administration (FDA) for a particular use or purpose or when used for a purpose other than the purpose for which the FDA approval is given, except as required by law or regulation.
- Fluids, solutions, nutrients, 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 provided in the Contract. NOTE: This exception does not apply to dietary formula necessary for the treatment of phenylketonuria (PKU) or other heritable diseases.
- Drugs prescribed and dispensed for the treatment of obesity or for use in any program of weight reduction, weight loss, or dietary control.
- Drugs the use or intended use of which would be illegal, unethical, imprudent, abusive, not Medically Necessary, or otherwise improper.
- Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the Identification Card.
- Drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction which is not covered under the Contract, or for which Benefits have been exhausted.
- Rogaine, minoxidil or any other drugs, medications, solutions or preparations used or intended for use in the treatment of hair loss, hair thinning or any related condition, whether to facilitate or promote hair growth, to replace lost hair, or otherwise.
- Any smoking cessation products requiring a Prescription Order.
- Cosmetic drugs used primarily to enhance appearance, including, but not limited to, correction of skin wrinkles and skin aging.
- 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 by the Plan.
- Retin-A or pharmacologically similar topical drugs for persons over the age of 30.
- Athletic performance enhancement drugs.
- Drugs to treat sexual dysfunction, including, but not limited to, sildenafil citrate (Viagra), phentolamine (Regitine), alprostadil (Prostin, Edex, Caverject), and apomorphine.
- Compounded medications. For purposes of this exclusion, "compounded medications" are substances made by mixing, reconstituting or other such acts, not in accordance with directions contained in Food and Drug Administration (FDA) approved labeling provided by the product's manufacturer and other FDA-approved manufacturer directions consistent with that labeling.
- Replacement of drugs or other items that have been lost, stolen, destroyed, or misplaced.
- Shipping, handling, or delivery charges.

ADDITIONAL EXCLUSIONS APPLICABLE TO OUTPATIENT PRESCRIPTION DRUGS (CONTINUED)

- Prescription Drugs required for international travel or work.
- Certain drug classes where there are over-the counter alternatives available.
- Nonsedating antihistamine drugs and combination medications containing a nonsedating antihistamine and decongestant.
- Drugs prescribed for the treatment of heartburn, gastroesophageal reflux disease (GERD), or acid reflux.
- Proton pump inhibitors.
- Drugs which are repackaged by a company other than the original manufacturer.
- Drugs used or intended to be used in the treatment to stimulate growth, including, but not limited to, self-administered injectable drugs.
- Drugs related to treatment of Mental Illness, substance abuse or chemical dependency.

Brand Name Drug Exclusion —Some equivalent drugs are manufactured under multiple brand names and have many therapeutic equivalents. In such cases, the Plan may limit Benefits to only one of the brand or therapeutic equivalents available. If you do not accept the brand or therapeutic equivalent that is covered under your Prescription Drug program, the drug purchased will not be covered under any Benefit level.

Pharmacy Discount Programs —In an effort to help offset the rising cost of Prescription Drugs, drug manufacturers may offer coupons or other drug discounts or rebates to Subscribers, which may impact the Benefits provided under this program. The total Benefits payable will not exceed the balance of the Allowable Charges remaining after all drug coupons, rebates or other drug discounts have been applied. You agree to reimburse the Plan any excess amounts for Benefits that we have paid and for which you are not eligible due to the application of drug coupons, rebates or other drug discounts.