BlueCross BlueShield of Oklahoma

1400 South Boston • P. O. Box 3283 • Tulsa, OK 74102-3283

Blue Preferred Silver PPO[SM] 004
Blue Preferred PPO[SM] Network

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.

This 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 Contract will be greater when you use the services of Network Providers.

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

The Contract 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.

This schedule shows the Deductibles, Copayments and/or Coinsurance amounts that apply to Covered Services described in the ***Comprehensive Health Care Services*** section of your Contract**.** Deductibles, Copayments, Coinsurance amounts and Out-of-Pocket Limits may be subject to change or increase as permitted by applicable law. **Please note that services must be Medically Necessary, as determined by the Plan, in order to be covered.**

COMPREHENSIVE HEALTH CARE SERVICES	
BENEFIT PERIOD/POLICY YEAR	Calendar Year
NETWORK PROVIDERS	To receive maximum Benefits under your Contract, you must receive services from Blue Preferred Providers in Oklahoma or BlueCard Providers outside the state of Oklahoma. Refer to www.bcbsok.com or call a Customer Service Representative at the number shown on your Identification Card to find a Network Provider near you.
OFFICE VISIT COPAYMENTS	The following Copayments will apply: • $35 for each visit to a Network Provider's office or Retail Health Clinic. • $35 for each visit to a Network Provider's office for Psychiatric Care Services. • $55 for each visit to a Network Specialist Physician's office. The Copayment applies to charges which are billed as part of the office visit, except for: • Preventive Care Services received from a Network Provider; • Annual mammography screening;

<table>
<tr><th colspan="2">COMPREHENSIVE HEALTH CARE SERVICES (CONTINUED)</th></tr>
<tr><td></td><td>• Covered childhood immunizations (for Subscribers under age 19);
• Surgical services;
• Physical Therapy, Occupational Therapy and Speech Therapy.

Copayments do not apply to services received from Out-of-Network Providers.</td></tr>
<tr><td colspan="2">DEDUCTIBLES</td></tr>
<tr><td>Emergency Room Deductible</td><td>$500 for each visit to a Hospital emergency room. This Deductible is waived if you are admitted to the Hospital through the emergency room visit.</td></tr>
<tr><td></td><td></td></tr>
<tr><td>Outpatient Surgery Deductible</td><td>• $200 for each visit to a Network Outpatient facility for Surgery. This Deductible applies to surgical procedures received in a Hospital Outpatient department or Ambulatory Surgical Facility.
• $300 for each visit to an Out-of-Network Outpatient facility for Surgery. This Deductible applies to surgical procedures received in an Out-of-Network Hospital Outpatient department or Ambulatory Surgical Facility.</td></tr>
<tr><td></td><td></td></tr>
<tr><td>Hospital Admission Deductible</td><td>• $250 for each admission to a Network Hospital.
• $350 for each Out-of-Network Hospital Admission.</td></tr>
<tr><td></td><td></td></tr>
<tr><td>Benefit Period Deductible</td><td>• Network Provider Services – $3,000 per Benefit Period per Subscriber, or $9,000 for all covered family members combined.
• Out-of-Network Provider Services – $6,000 per Benefit Period per Subscriber, or $18,000 for all covered family members combined.

Deductible amounts for Network Provider Services and Out-of-Network Provider Services do not cross-apply.

The Benefit Period Deductible is in addition to the Emergency Room Deductible, Outpatient Surgery Deductible and Hospital Admission Deductible described above.

The Benefit Period Deductible applies to all Covered Services, except:
• Network Physician services that are subject to the office visit Copayment.
• Preventive Care Services received from a Network Provider. Preventive Care Services received from an Out-of-Network Provider are subject to Deductible, except for:
– 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 a Deductible may not be required.</td></tr>
</table>

COMPREHENSIVE HEALTH CARE SERVICES (CONTINUED)	
OUT–OF–POCKET LIMIT	• **Network Provider Services** – $6,350 per Subscriber, or $12,700 for all covered family members combined. When this limit has been paid (including any Copayment and/or Deductible amounts) for Covered Services provided by Network Providers during a Benefit Period, the amount of Allowable Charges covered by the Plan for such Subscriber will increase to 100% during the remainder of the Benefit Period for Covered Services received from Network Providers. • **Out-of-Network Provider Services** – $12,700 per Subscriber, or $25,400 for all covered family members combined. When this limit has been paid (including any Deductible amounts) for Covered Services provided by Out-of-Network Providers during a Benefit Period, the amount of Allowable Charges covered by the Plan will increase to 100% during the remainder of the Benefit Period for Out-of-Network Provider services. Out-of-Pocket Limits for Network Provider Services and Out-of-Network Provider Services ***do not*** cross-apply. This Out-of- Pocket Limit does not include any of the following: • Services, supplies or charges limited or excluded by the Contract; • Expenses not covered because a Benefit maximum has been reached; • Any penalty incurred due to your failure to follow the Plan's requirements for Preauthorization, as set forth in the Contract.
BENEFIT PERCENTAGE AMOUNT	The following chart shows the percentage of Allowable Charges covered by the Contract through payments and/or contractual arrangements with Providers. These percentages apply only after your Deductibles and/or Copayment amounts have been satisfied. **NOTE: Any services classified as "Preventive Care Services" are paid at 100% of the Allowable Charge and are not subject to Copayments, Deductibles and/or Coinsurance, provided such services are received from Network Providers.**

COVERED SERVICES

(Subject to the *Comprehensive Health Care Services* section)

	BENEFIT PERCENTAGE OF ALLOWABLE CHARGES PAID BY THE PLAN	
	Network 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	80%	80%
THE FOLLOWING BENEFIT PERCENTAGES APPLY TO SERVICES THAT ARE NOT CLASSIFIED AS PREVENTIVE CARE SERVICES OR EMERGENCY CARE SERVICES, AS DETERMINED BY THE PLAN		

COVERED SERVICES **(Subject to the *Comprehensive Health Care Services* section)**		
	BENEFIT PERCENTAGE OF ALLOWABLE CHARGES PAID BY THE PLAN	
	Network Provider Services	**Out-of-Network Provider Services**
HOSPITAL SERVICES[1]	80%	60%
SURGICAL/MEDICAL SERVICES		
Physician's Office Visit	100%[2]	70%
Retail Health Clinic Visit	100%[2]	70%
All Other Covered Surgical/Medical Services	80%	60%
OUTPATIENT DIAGNOSTIC SERVICES	80%	60%
OUTPATIENT THERAPY SERVICES Maximum of 25 Outpatient visits for Physical Therapy, Occupational Therapy and Speech Therapy (combined) per Benefit Period	80%	60%
MATERNITY SERVICES	80%	60%
MASTECTOMY AND RECONSTRUCTIVE SURGICAL SERVICES	80%	60%
HUMAN ORGAN, TISSUE AND BONE MARROW TRANSPLANT SERVICES[3]	80%	60%
AMBULATORY SURGICAL FACILITY SERVICES	80%	60%
SERVICES RELATED TO TREATMENT OF AUTISM AND AUTISM SPECTRUM DISORDERS Physical Therapy, Occupational Therapy and Speech Therapy limited to a combined maximum of 390 visits per Benefit Period for Subscribers under age six[4]	80%	60%
PSYCHIATRIC CARE SERVICES	80%	60%
AMBULANCE SERVICES	80%	80%
PRIVATE DUTY NURSING SERVICES[3] 85 visit maximum per Benefit Period	80%	60%
REHABILITATION CARE[3] 30-day maximum per Benefit Period	80%	60%

[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 80% of Allowable Charges after satisfaction of the Deductible.*
[3] *Subject to Preauthorization approval from the Plan. See the Contract for details regarding "Preauthorization" requirements.*
[4] *Refer to "Outpatient Therapy Services" for Physical Therapy, Occupational Therapy and Speech Therapy visits applicable to Subscribers age six and older.*

COVERED SERVICES (Subject to the *Comprehensive Health Care Services* section)		
	BENEFIT PERCENTAGE OF ALLOWABLE CHARGES PAID BY THE PLAN	
	Network Provider Services	**Out-of-Network Provider Services**
SKILLED NURSING FACILITY SERVICES[1] 30-day maximum per Benefit Period	80%	60%
HOME HEALTH CARE SERVICES[1] 30 visit maximum per Benefit Period	80%	60%
HOSPICE SERVICES[1]	80%	60%
DENTAL SERVICES FOR ACCIDENTAL INJURY	80%	60%
DIABETES EQUIPMENT, SUPPLIES AND SELF-MANAGEMENT SERVICES	80%	60%
SERVICES RELATED TO CLINICAL TRIALS	80%	60%
DURABLE MEDICAL EQUIPMENT	80%	60%
PROSTHETIC APPLIANCES	80%	60%
ORTHOTIC DEVICES Maximum of 15 per Benefit Period	80%	60%
WIGS OR OTHER SCALP PROSTHESES Maximum of One per Benefit Period	80%	60%
ALL OTHER COVERED SERVICES	80%	60%

EXCLUSIONS

What Is Not Covered

Except as otherwise specifically stated in the Contract, we do not provide Benefits for services, supplies or charges:

- Which are not prescribed by or performed by or upon the direction of a Physician or other Provider.
- Which the Plan determines 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 and/or Unproven 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).

[1] *Subject to Preauthorization approval from the Plan. See the Contract for details regarding "Preauthorization" requirements.*

EXCLUSIONS (CONTINUED)

- 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.
- Any services and supplies provided to a Subscriber incurred outside the United States if the Subscriber traveled to the location for the purposes of receiving medical services, supplies, or drugs.
- 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 resulting from a congenital defect.

  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.
- Received from a member of your immediate family.
- Received before your Effective Date.
- Received after your coverage stops.
- 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.
- 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 (except electronic consultations occurring with a Provider in connection with a "medical home" program that has been approved by the Plan), missed appointments, or completion of a claim form.
- For Custodial Care such as sitters' or homemakers' services, or care in a place that serves you primarily as a residence when you do not require skilled nursing.
- 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 which are not included as "Preventive Care Services," as specified in the ***Comprehensive Health Care Services*** section of the Contract.
- For reverse sterilization.
- For female contraceptive devices when not prescribed by a licensed Provider, including over-the-counter contraceptive products. Contraceptive medications or devices for male use are excluded.
- 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 resulting from a congenital defect.

  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; or
  - four years of age or under, who in the judgment of the practitioner treating the child, is not of sufficient emotional development to undergo a Medically Necessary dental procedure without the use of anesthesia.
- 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 performed in connection with the diagnosis or treatment of disease or injury; or
  - services specified under *"Preventive Care Services"* or "Pediatric Vision Care Addendum*"*.

EXCLUSIONS (CONTINUED)

- 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 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, not including counseling as specified under "Preventive Care Services".
- For medication, drugs or hormones to stimulate growth.
- For or related to acupuncture, whether for medical or anesthesia purposes.
- For conditions related to 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 of 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); or
  - Prescription Drug therapy for treatment of ADD/ADHD.
- For unspecified developmental disorders or autistic disease of childhood, except as specified in the ***Comprehensive Health Care Services*** section under *"*Services Related to Treatment of Autism and Autism Spectrum Disorders*."*
- For or related to applied behavior analysis.
- 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 elective abortion, unless the life or health of the mother is endangered.
- For transcutaneous electrical nerve stimulator (TENS).
- For Inpatient drug and alcohol treatment that is not rendered in a Hospital, Psychiatric Hospital, Residential Treatment Center or other Plan-approved Provider.
- For massage therapy, including but not limited to effleurage, petrissage and/or tapotement.
- Which are not specifically named as Covered Services subject to any other specific Exclusions and limitations in the Contract.

EXCLUSIONS (CONTINUED)		
We may, without waiving these Exclusions, elect to provide Benefits for care and services while awaiting the decision of whether or not the care and services fall within the Exclusions listed above. If it is later determined that the care and services are excluded from your coverage, we will be entitled to recover the amount we have allowed for Benefits under the Contract. You must provide to us all documents needed to enforce our rights under this provision.		
OUTPATIENT PRESCRIPTION DRUGS		
BENEFIT PERIOD/POLICY YEAR	Calendar Year	
DEDUCTIBLE	None. Your Benefits for Outpatient Prescription Drugs and related services are *not* subject to the Benefit Period Deductible set forth in the ***Schedule of Benefits for Comprehensive Health Care Services***.	
OUT-OF-POCKET LIMIT	Your Benefits for Outpatient Prescription Drugs and related services are subject to the Out-of-Pocket Limit set forth in the ***Schedule of Benefits for Comprehensive Health Care Services.***	
COPAYMENT/COINSURANCE	The Copayment/Coinsurance amount applicable to each Prescription Order is set forth below. **In addition to your Copayment and/or Coinsurance amounts, when your Prescription Order is filled at an Out-of-Network Pharmacy you will be responsible for the cost difference, if any, between the Pharmacy's billed charges and the Allowable Charge determined by the Plan.**	
	Copayment/Coinsurance Amounts per Prescription Order For Which You Are Responsible	
Retail Pharmacy Program (30-Day Supply)	**Participating Retail Pharmacy**	**Out-of-Network Retail Pharmacy**[1]
Preferred Generic Drugs	No Copayment	50% of Allowable Charges
Non-Preferred Generic Drugs	$10 Copayment	$10 Copayment plus 50% of Allowable Charges
Preferred Brand Drugs	$50 Copayment	$50 Copayment plus 50% of Allowable Charges
Non-Preferred Brand Drugs	$100 Copayment	$100 Copayment plus 50% of Allowable Charges

[1] *In addition to any Copayment and/or Coinsurance amounts, you are also responsible for any charges which exceed the Allowable Charges determined by the Plan.*

OUTPATIENT PRESCRIPTION DRUGS (CONTINUED)			
	Copayment/Coinsurance Amounts per Prescription Order For Which You Are Responsible		
Extended Retail Prescription Drug Supply Program (90-Day Supply)	**Quantity Dispensed**	**Participating Extended Supply Retail Pharmacy**	**Any Pharmacy other than the Participating Extended Supply Retail Pharmacy**
Preferred Generic Drugs	1 to 90 days	No Copayment	Not Covered
Non-Preferred Generic Drugs	1 to 30 days	$10 Copayment	Not Covered
	31 to 60 days	$20 Copayment	
	61 to 90 days	$30 Copayment	
Preferred Brand Drugs	1 to 30 days	$50 Copayment	Not Covered
	31 to 60 days	$100 Copayment	
	61 to 90 days	$150 Copayment	
Non-Preferred Brand Drugs	1 to 30 days	$100 Copayment	Not Covered
	31 to 60 days	$200 Copayment	
	61 to 90 days	$300 Copayment	

	Copayment/Coinsurance Amounts per Prescription Order For Which You Are Responsible	
Mail-Order Pharmacy Program (90-Day Supply)	**Participating Mail-Order Pharmacy**	**Any Pharmacy other than the Participating Mail-Order Pharmacy**
Preferred Generic Drugs	No Copayment	Not Covered
Non-Preferred Generic Drugs	$20 Copayment	Not Covered
Preferred Brand Drugs	$100 Copayment	Not Covered
Non-Preferred Brand Drugs	$200 Copayment	Not Covered
	Copayment/Coinsurance Amounts per Prescription Order For Which You Are Responsible	
	Specialty Network Pharmacy	**Any Pharmacy other than a Specialty Network Pharmacy**[1]
Specialty Pharmacy Program (30-Day Supply)	$150 Copayment	$150 Copayment plus 50% of Allowable Charges

Brand Name Drug Selection

If you receive a Brand Name Drug when a Generic Drug is available, you will be responsible for the difference between the Allowable Charge for the Brand Name Drug and the Allowable Charge for the Generic Drug equivalent. This amount is in addition to any Deductible, Copayment and/or Coinsurance amount set forth in the ***Schedule of Benefits***.

[1] *In addition to any Copayment and/or Coinsurance amounts, you are also responsible for any charges which exceed the Allowable Charges determined by the Plan.*

Exclusions

In addition to the exclusions and limitations specified in the ***Exclusions*** section of the Contract, no Benefits will be provided under the ***Outpatient Prescription Drugs and Related Services*** 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.
- Over-the-counter drugs and medications, except those prescribed by a Physician or other Provider as part of the "Preventive Care Services" as defined in the Contract.
- Devices or Durable Medical Equipment of any type (even though such devices may require a Prescription Order), such as, but not limited to, therapeutic devices, artificial appliances, or similar devices (**except** disposable hypodermic needles and syringes for self-administered injections.)
- 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.
- 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 Copayment or Coinsurance amount provided under the Contract.
- Infertility and fertility medications.
- 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 claim is made for the drugs.
- Covered Drugs dispensed in quantities in excess of the amounts stipulated in the ***Outpatient Prescription Drugs and Related Services*** 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. This exclusion is not applicable to the coverage of the off-label use of Prescription Drugs for the treatment of cancer or the study of oncology in accordance with Oklahoma law.
- 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.
- Cosmetic drugs used primarily to enhance appearance, including, but not limited to, correction of skin wrinkles and skin aging.

EXCLUSIONS (CONTINUED)
• 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. • Athletic performance enhancement drugs. • Drugs to treat sexual dysfunction or erectile 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. • Prescription Drugs required for international travel or work. • Certain drug classes where there are over-the counter alternatives available. • Drugs which are repackaged by a company other than the original manufacturer.
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.

PEDIATRIC VISION CARE BENEFITS		
Vision Care Services	**In-Network Subscriber Cost or Discount** (When a fixed-dollar Copayment is due from the Subscriber, the remainder is payable by the Plan up to the Allowable Charge[1])	**Out-of-Network Allowance** (Maximum amount payable by Plan, not to exceed the retail cost[2])
Exam (with dilation as necessary):	No Copayment	Up to $30
Frames:		
"Collection" Frames	No Copayment	Up to $30
Frequency: Examination, Frames, Lenses, or Contact Lenses	Once every Calendar Year	
Standard Plastic, Glass, or Poly Spectacle Lenses: Single Vision Lined Bifocal Lined Trifocal Lenticular	 No Copayment No Copayment No Copayment No Copayment	 Up to $25 Up to $35 Up to $45 Up to $45
Lens Options (add to lens prices above): Ultraviolet Protective Coating Polycarbonate Lenses Blended Segment Lenses Intermediate vision Lenses Standard Progressives Premium Progressive (Varilux®, etc.) Photochromic Glass Lenses Plastic Photosensitive Lenses (Transitions®) Polarized Lenses Standard Anti-Reflective (AR) Coating Premium AR Coating	 No Copayment No Copayment $20 Copayment $30 Copayment No Copayment $90 Copayment $20 Copayment No Copayment $75 Copayment $35 Copayment $48 Copayment	Not covered

[1] *The "Allowable Charge" is the rate negotiated with Network Providers for a particular Covered Service.*
[2] *The Plan pays the lesser of the maximum allowance noted or the retail cost. Retail prices vary by location.*

PEDIATRIC VISION CARE BENEFITS (CONTINUED)		
Ultra AR Coating High Index Lenses **Progressive Lens Options – Subscribers may receive a discount on additional progressive lens options:** Select Progressive Lenses Ultra Progressive Lenses	$60 Copayment $55 Copayment $70 Copayment $195 Copayment	
For additional options and added features refer to your Contract.		

EXCLUSIONS

In addition to the ***Exclusions*** listed in your Contract, services or materials connected with or charges arising from the following are not covered:

- any vision service, treatment or materials not specifically listed as a Covered Service;
- services and materials not meeting accepted standards of optometric practice;
- services and materials resulting from your failure to comply with professionally prescribed treatment;
- telephone consultations;
- any services that are strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
- services or materials provided as a result of intentionally self-inflicted injury or illness;
- services or materials provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection;
- office infection control charges;
- charges for copies of your records, charts, or any costs associated with forwarding/mailing copies of your records or charts;
- state or territorial taxes on vision services performed;
- medical treatment of eye disease or injury;
- visual therapy;
- special lens designs or coatings other than those described in your Contract;
- replacement of lost/stolen eyewear;
- non-prescription (Plano) lenses;
- two pairs of eyeglasses in lieu of bifocals;
- services not performed by licensed personnel;
- prosthetic devices and services;
- insurance of contact lenses;
- professional services you receive from immediate relatives or household members, such as a spouse, parent, child, brother or sister, by blood, marriage or adoption;
- services covered under your ***Comprehensive Health Care Services.***