

PPO BLUE

PPO PROGRAM

HHIC Shared Cost PPO \$1500 OFFX

Effective January 1, 2014

Produced January, 2014

Summary of Benefits

This Summary of Benefits outlines your covered services. More details can be found in the Covered Services section.

Benefits	Network	Out-of-Network
General Provisions		
Benefit Period ¹	Contract Year	
Deductible (per benefit period)		
Individual	\$1,500	\$3,000
Family	\$3,000	\$6,000
Plan Payment Level - Based on the plan allowance	90% after deductible until out-of-pocket limit is met; then 100%	70% after deductible until out-of-pocket limit is met; then 100%
Out-of-Pocket Limits		
Individual	\$2,800	\$5,000
Family	\$5,600	\$10,000
Lifetime Maximum (per member)	Unlimited	
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits	100% after \$30 copayment; deductible does not apply	70% after deductible
Primary Care Provider Office Visits ^{2,3}	100% after \$30 copayment; deductible does not apply	70% after deductible
Specialist Office Visits ² (including virtual visits)	100% after \$50 copayment; deductible does not apply	70% after deductible
Virtual Visit Originating Site Fee ²	90% after deductible	70% after deductible
Urgent Care Center Visits	100% after \$60 copayment; deductible does not apply	70% after deductible
Telemedicine Services	100% after \$20 copayment; deductible does not apply	Same as network services
Preventive Care Services ⁴		
Adult		
Routine physical exams	100%; deductible does not apply	70% after deductible
Adult Immunizations	100%; deductible does not apply	70% after deductible
Diagnostic services and procedures	100%; deductible does not apply	70% after deductible
Routine gynecological exams, including a PAP Test	100%; deductible does not apply	70% after deductible
Mammograms, annual routine and medically necessary	100%; deductible does not apply	70% after deductible
Colorectal Cancer Screening	100%; deductible does not apply	70% after deductible
Routine adult vision exam	Not Covered	
Pediatric		
Routine physical exams	100%; deductible does not apply	70% after deductible
Pediatric immunizations	100%; deductible does not apply	70% after deductible
Diagnostic services and procedures	100%; deductible does not apply	70% after deductible
Pediatric Vision ⁵		
Exam (including dilation, as professionally indicated)	100%; deductible does not apply	Not Covered
Pediatric frame selection	100%; deductible does not apply	Not Covered
Standard eyeglass lenses (per pair)	100%; deductible does not apply	Not Covered
Pediatric Dental ⁵		
Exams and cleanings	100%; deductible does not apply	Not Covered
Basic services	50%; deductible does not apply	Not Covered

Benefits	Network	Out-of-Network
<i>Major services</i>	50%; deductible does not apply	Not Covered
<i>Orthodontics⁶</i>	50%; deductible does not apply	Not Covered
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Services - Inpatient	90% after deductible	70% after deductible
Hospital Services - Outpatient⁷	90% after deductible	70% after deductible
Maternity (non-preventive facility and professional services)	90% after deductible	70% after deductible
Medical/Surgical Expenses (except office visits)	90% after deductible	70% after deductible
Emergency Services		
Emergency Room Services	100% after \$125 copayment (waived if admitted as an inpatient); deductible does not apply	Same as network services
Ambulance	90% after deductible	90% after in network deductible
Therapy, Rehabilitative and Habilitative Services		
Infusion Therapy	90% after deductible	70% after deductible
Occupational Therapy (Rehabilitative and Habilitative)	100% after \$50 copayment; deductible does not apply	70% after deductible
	Combined Limit: 30 rehab/habilitative visits per benefit period	
Physical Medicine (Rehabilitative and Habilitative)	100% after \$50 copayment; deductible does not apply	70% after deductible
	Combined Limit: 30 rehab/habilitative visits per benefit period	
Radiation Therapy	90% after deductible	70% after deductible
Respiratory Therapy	90% after deductible	70% after deductible
Speech Therapy (Rehabilitative and Habilitative)	100% after \$50 copayment; deductible does not apply	70% after deductible
	Combined Limit: 30 rehab/habilitative visits per benefit period	
Spinal Manipulations	100% after \$50 copayment; deductible does not apply	70% after deductible
	Combined Limit: 20 visits per benefit period	
Other Therapy Services (Cardiac Rehabilitation, Chemotherapy, and Dialysis Treatment)	90% after deductible	70% after deductible
Mental Health/Substance Abuse Services		
Mental Health Care Services - Inpatient	90% after deductible	70% after deductible
Mental Health Care Services - Outpatient	100% after \$50 copayment; deductible does not apply	70% after deductible
Substance Abuse Services - Inpatient Detoxification	90% after deductible	70% after deductible
Substance Abuse Services - Inpatient Residential Treatment and Rehabilitation Services	90% after deductible	70% after deductible
Substance Abuse Services - Outpatient	100% after \$50 copayment; deductible does not apply	70% after deductible
Other Services		
Allergy Extracts and Injections	90% after deductible	70% after deductible
Anesthesia for Non-Covered Dental Procedures (Limited)	90% after deductible	70% after deductible
Assisted Fertilization Treatment	Not Covered	
Diabetes Treatment	90% after deductible	70% after deductible

Benefits	Network	Out-of-Network
Diagnostic Services <i>Advanced Imaging (MRI, CAT Scan, PET scan, etc.)</i>	100% after \$100 copayment; deductible does not apply	70% after deductible
<i>Basic Diagnostic Services</i> <ul style="list-style-type: none"> • standard imaging • diagnostic medical • lab/pathology • allergy testing 	100% after \$50 copayment; deductible does not apply	70% after deductible
Durable Medical Equipment	90% after deductible	70% after deductible
Enteral Formulae	90%; deductible does not apply	70% after deductible
Home Infusion and Suite Infusion Therapy Services	90% after deductible	70% after deductible
Home Health Care⁸	90% after deductible	70% after deductible
	Combined Limit: 90 visits per benefit period	
Hospice	90% after deductible	70% after deductible
Infertility Counseling, Testing and Treatment	90% after deductible	70% after deductible
Orthotics	90% after deductible	70% after deductible
Pediatric Extended Care Services	90% after deductible	70% after deductible
	Combined Limit: 100 days per benefit period	
Private Duty Nursing	90% after deductible	70% after deductible
	Combined Limit: 240 hours per benefit period	
Prosthetics	90% after deductible	70% after deductible
Skilled Nursing Facility Care	90% after deductible	70% after deductible
	Combined Limit: 120 days per benefit period	
Transplant Services	90% after deductible	70% after deductible
Precertification Requirements	Yes ⁹	

Note: Certain benefits may be subject to day, visit, and/or hour limits. In connection with such benefits, all services you receive during a benefit period will reduce the remaining number of days, visits, and/or hours available under that benefit, regardless of whether you have satisfied your deductible.

- ¹ Your group's benefit period is based on a contract year. The contract year is a consecutive 12-month period beginning on January 1.
- ² You *may* be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a hospital, facility provider, ancillary provider, retail clinic or urgent care center. The specialist virtual visit is subject to availability within your service area..
- ³ A physician whose practice is limited to family practice, general practice, internal medicine or pediatrics.
- ⁴ Services are limited to those on the Highmark Preventive Schedule and the Women's Health Preventive Schedule. Gender, age and frequency limits may apply.
- ⁵ Pediatric vision and dental benefits are only available to dependent children or health plan members under age 19.
- ⁶ A medically necessary orthodontic service is an orthodontic procedure that occurs as part of an approved orthodontic plan that is intended to treat a severe dentofacial abnormality. Prior approval is required. A 12-month waiting period is required.
- ⁷ Other cost sharing provisions and/or limits may apply to specific benefits, i.e., physical medicine, therapies, diagnostic services, mental health/substance abuse visits.
- ⁸ The maternity home health care visit for network care is not subject to the program copayment, coinsurance or deductible amounts, if applicable. See Maternity Home Health Care Visit in the Covered Services section.

- ⁹ Highmark must be contacted prior to a planned inpatient admission or within 48 hours of an emergency inpatient admission. Some facility providers will contact Highmark and obtain precertification of the inpatient admission on your behalf. Be sure to verify that your provider is contacting Highmark for precertification. If not, you are responsible for contacting Highmark. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, the patient will be responsible for payment of any costs not covered.

Prescription Drug Benefits Mandatory Generic ¹	Retail Pharmacy Up to 31/60/90-day supply ^{2 3}	Maintenance Prescription Drugs through Mail Order Up to 90-day supply
Pharmacy Network	Premier 2012	Express Scripts Pharmacy
The following are your PPO Blue program cost-sharing provisions which include your medical and prescription drug benefits		
Out-Of-Pocket Limit	\$2,800 Individual \$5,600 Family	
Generic Prescription Drug	\$8/\$16/\$24 copayment	\$20 copayment
Brand Formulary Prescription Drug⁴	\$40/\$80/\$120 copayment	\$100 copayment
Brand Non-Formulary Prescription Drug	\$70/\$140/\$210 copayment	\$175 copayment
Preventive Medications		
Preventive Covered Drugs⁵	Deductibles, coinsurance and/or copayments do not apply	

- ¹ You are responsible for the payment differential when a generic drug is authorized by the physician and the patient purchases a brand name drug. Your payment is the price difference between the brand drug and generic drug in addition to the brand drug copayment or coinsurance amounts which may apply.
- ² Certain retail participating pharmacy providers may have agreed to make covered medications available at the same cost-sharing and quantity limits as the mail order coverage. You may contact Highmark at the toll-free number or the Web site appearing on the back of your ID card for a listing of those pharmacies who have agreed to do so.
- ³ The quantity level limit for your initial prescription order may be reduced, depending on the particular medication, to a quantity level necessary to establish that you can tolerate the medication. The cost-sharing provisions indicated above will be adjusted accordingly for the initial prescription order based upon the initial quantity dispensed. If you are able to tolerate the medication, the remainder of the available days supply for the initial prescription order will be filled and you will be responsible for the balance of the applicable cost-sharing amount indicated above.
- ⁴ The Highmark formulary is an extensive list of Food & Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. It includes products in every major therapeutic category. The formulary was developed by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians and may, from time to time, be revised by the committee. Your program includes coverage for both formulary and non-formulary drugs at the specific copayment or coinsurance amounts listed above.
- ⁵ This includes prescriptions and over-the-counter drugs that are set forth within the predefined schedule and that are prescribed for preventive purposes. Please refer to the Covered Services - Prescription Drug Program section for more information.

What Is Not Covered

Except as specifically provided in this program or as Highmark is mandated or required to provide based on state or federal law, no benefits will be provided for services, supplies, prescription drugs or charges:

<u>Key Word</u>	<u>Exclusion</u>
Abortion	<ul style="list-style-type: none">• For elective abortions except those abortions necessary to avert the death of the mother or terminate pregnancies caused by rape or incest.
Allergy Testing	<ul style="list-style-type: none">• For allergy testing, except as provided herein.
Ambulance	<ul style="list-style-type: none">• For ambulance services, except as provided herein.
Assisted Fertilization	<ul style="list-style-type: none">• Related to treatment provided specifically for the purpose of assisted fertilization, including pharmacological or hormonal treatments used in conjunction with assisted fertilization.
Comfort/Convenience Items	<ul style="list-style-type: none">• For personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, or physical fitness equipment, stair glides, elevators/lifts or "barrier free" home modifications, whether or not specifically recommended by a professional provider.
Cosmetic Surgery	<ul style="list-style-type: none">• For operations for cosmetic purposes done to improve the appearance of any portion of the body, and from which no improvement in physiological function can be expected, except as otherwise provided herein. Other exceptions to this exclusion are: a) surgery to correct a condition resulting from an accident; b) surgery to correct a congenital birth defect; and c) surgery to correct a functional impairment which results from a covered

disease or injury.

Court Ordered Services

- For otherwise covered services ordered by a court or other tribunal as part of your or your dependent's sentence.

Custodial Care

- For custodial care, domiciliary care, residential care, protective and supportive care including educational services, rest cures and convalescent care.

Dental Care

- Directly related to the care, filling, removal or replacement of teeth, the treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth. These include, but are not limited to, apicoectomy (dental root resection), root canal treatments, soft tissue impactions, alveolectomy and treatment of periodontal disease, except for dental expenses related to accidental injury, anesthesia for non-covered dental procedures and orthodontic treatment for congenital cleft palates as provided herein.

Dental Care (Pediatric)

- For treatment started prior to the member's effective date or after the termination date of coverage under this program (e.g., multi-visit procedures such as endodontics, crowns, fixed partial dentures, inlays, onlays and dentures).
- For house or hospital calls for dental services and for hospitalization costs (e.g., facility-use fees).
- For prescription and non-prescription drugs, vitamins or dietary supplements.
- For administration of nitrous oxide and/or IV sedation, unless specifically provided herein.
- Cosmetic in nature, as determined by Highmark (e.g., bleaching, veneer facings, personalization or characterization of crowns, fixed partial dentures and/or dentures).

- Elective procedures (e.g., the prophylactic extraction of third molars).
- For congenital mouth malformations or skeletal imbalances (e.g., treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery including orthodontic treatment). This exclusion does not apply to the treatment of medically diagnosed congenital defects or birth abnormalities of a newborn child or newly adopted children, regardless of age.
- For dental implants and any related surgery, placement, restoration, prosthetics (except single implant crowns), maintenance and removal of implants, unless specifically provided herein.
- Diagnostic services and treatment of jaw joint problems by any method unless specifically provided herein. Examples of these jaw joint problems are temporomandibular joint disorders (TMD) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to the joint.
- For treatment of fractures and dislocations of the jaw.
- For treatment of malignancies or neoplasms.
- Services and/or appliances that alter the vertical dimension (e.g. full-mouth rehabilitation, splinting, fillings) to restore tooth structure lost from attrition, erosion or abrasion, appliances or any other method.
- Replacement or repair of lost, stolen or damaged prosthetic or orthodontic appliances.
- Preventive restorations unless specifically provided herein.
- Periodontal splinting of teeth by any method.
- For duplicate dentures, prosthetic devices or any other

duplicative device.

- Maxillofacial prosthetics.
- For plaque control programs, tobacco counseling, oral hygiene and dietary instructions.
- For treatment and appliances for bruxism (e.g., night-grinding of teeth).
- For any claims submitted to Highmark by you or on your behalf in excess of 12 months after the date of service, unless such claims are submitted to Highmark as soon as reasonably possible.
- Incomplete treatment (e.g. patient does not return to complete treatment) and temporary services (e.g. temporary restorations).
- Procedures that are i) part of a service but are reported as separate services, ii) reported in a treatment sequence that is not appropriate; or iii) misreported or which represent a procedure other than the one reported.
- Specialized procedures and techniques (e.g. precision attachments, copings and intentional root canal treatment).
- Services not dental necessary and appropriate or not deemed to be generally accepted standards of dental treatment. If no clear or generally accepted standards exist, or there are varying positions within the professional community, the opinion of Highmark will apply.
- For implantology services to replace one or more teeth missing prior to your effective date of coverage.
- For adjunctive general services.
- For other diagnostic or preventive dental services not provided herein.
- For the following orthodontic services: i) treatments that are primarily for cosmetic reasons; ii) treatments for congenital

mouth malformations or skeletal imbalances (e.g. treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery including orthodontic treatment); iii) diagnostic services and treatment of jaw joint problems by any method unless specifically covered under the Summary of Benefits. Examples of these jaw joint problems are TMD and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to the joint.

Effective Date

- Rendered prior to your effective date of coverage.

Enteral Formulae

- For the following services associated with the additional enteral formulae benefits provided under your program: blenderized food, baby food, or regular shelf food when used with an enteral system; milk or soy-based infant formulae with intact proteins; any formulae, when used for the convenience of you or your family members; nutritional supplements or any other substance utilized for the sole purpose of weight loss or gain, or for caloric supplementation, limitation or maintenance; semisynthetic intact protein/protein isolates, natural intact protein/protein isolates, and intact protein/protein isolates, when provided orally; normal food products used in the dietary management of rare hereditary genetic metabolic disorders.

Experimental/ Investigative

- Which are experimental/investigative in nature.

Eyeglasses/Contact Lenses

- For eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses (except for the initial pair of contact lenses/glasses prescribed following cataract extraction in place of surgically implanted lenses, or sclera shells intended for use in the treatment of disease or

injury) except as provided herein for members under age 19.

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| Felonies | <ul style="list-style-type: none">• For any illness or injury you suffer during your commission of a felony, as long as such illness or injuries are not the result of a medical condition or an act of domestic violence. |
| Foot Care | <ul style="list-style-type: none">• For palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, corrective shoes, the treatment of subluxations of the foot, care of corns, bunions, (except capsular or bone surgery), calluses, toe nails (except surgery for ingrown toe nails), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet, except when such devices or services are related to the treatment of diabetes. |
| Healthcare Management program | <ul style="list-style-type: none">• For any care, treatment, prescription drug or service which has been disallowed under the provisions of Healthcare Management program. |
| Hearing Care Services | <ul style="list-style-type: none">• For hearing aid devices, tinnitus maskers, or examinations for the prescription or fitting of hearing aids. |
| Home Health Care | <ul style="list-style-type: none">• For the following services you receive from a home health care agency, hospice or a hospital program for home health care and/or hospice care: dietitian services; homemaker services; maintenance therapy; dialysis treatment; custodial care; food or home-delivered meals. |
| Immunizations | <ul style="list-style-type: none">• For immunizations required for foreign travel or employment. |
| Inpatient Admissions | <ul style="list-style-type: none">• For inpatient admissions which are primarily for diagnostic studies.• For inpatient admissions which are primarily for physical |

medicine services.

Learning Disabilities

- For any care that is related to conditions such as autistic disease of childhood, hyperkinetic syndromes, learning disabilities, behavioral problems or mental retardation, which extends beyond traditional medical management or for inpatient confinement for environmental change. Care which extends beyond traditional medical management or for inpatient confinement for environmental change includes the following:
 - a) services that are primarily educational in nature, such as academic skills training or those for remedial education or those that may be delivered in a classroom-type setting, including tutorial services;
 - b) neuropsychological testing, educational testing (such as I.Q., mental ability, achievement and aptitude testing), except for specific evaluation purposes directly related to medical treatment;
 - c) services provided for purposes of behavioral modification and/or training;
 - d) services related to the treatment of learning disorders or learning disabilities;
 - e) services provided primarily for social or environmental change or for respite care;
 - f) developmental or cognitive therapies that are not restorative in nature but used to facilitate or promote the development of skills which the member has not yet attained; and
 - g) services provided for which, based on medical standards, there is no established expectation of achieving measurable, sustainable improvement in a reasonable and predictable period of time.

Legal Obligation

- For which you would have no legal obligation to pay.

Medically Necessary and Appropriate	<ul style="list-style-type: none"> • Which are not medically necessary and appropriate as determined by Highmark.
Medicare	<ul style="list-style-type: none"> • To the extent payment has been made under Medicare when Medicare is primary; however, this exclusion shall not apply when the group is obligated by law to offer you all the benefits of this program and you elect this coverage as primary.
Methadone Hydrochloride	<ul style="list-style-type: none"> • For methadone hydrochloride treatment for which no additional functional progress is expected to occur.
Military Service	<ul style="list-style-type: none"> • To the extent benefits are provided to members of the armed forces while on active duty or to patients in Veteran's Administration facilities for service connected illness or injury, unless you have a legal obligation to pay.
Miscellaneous	<ul style="list-style-type: none"> • For telephone consultations which do not involve telemedicine services, charges for failure to keep a scheduled visit, or charges for completion of a claim form. • For any other medical or dental service or treatment or prescription drug except as provided herein.
Motor Vehicle Accident	<ul style="list-style-type: none"> • For treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified or qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law, including medical benefits payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Act.
Nutritional Counseling	<ul style="list-style-type: none"> • For nutritional counseling, except as provided herein.
Obesity	<ul style="list-style-type: none"> • For treatment of obesity, except for medical and surgical

treatment of morbid obesity or as otherwise set forth in the predefined preventive schedule. Please refer to the Preventive Services section of Covered Services for more information.

Oral Surgery

- For oral surgery procedures, except as provided herein.

Physical Examinations

- For routine or periodic physical examinations, the completion of forms, and the preparation of specialized reports solely for insurance, licensing, employment or other non-preventive purposes, such as pre-marital examinations, physicals for school, camp, sports or travel, which are not medically necessary and appropriate, except as provided herein.

Prescription Drugs
(Medical Program)

- For prescription drugs which were paid or are payable under a freestanding prescription drug program.

Preventive Care Services

- For preventive care services, wellness services or programs, except as provided herein.

Provider of Service

- Which are not prescribed by or performed by or upon the direction of a professional provider.
- Rendered by other than ancillary providers, facility providers or professional providers.
- Received from a dental or medical department maintained, in whole or in part, by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group.
- Which are submitted by a certified registered nurse and another professional provider for the same services performed on the same date for the same member.
- Rendered by a provider who is a member of your immediate family.

	<ul style="list-style-type: none"> • Performed by a professional provider enrolled in an education or training program when such services are related to the education or training program.
Respite Care	<ul style="list-style-type: none"> • For respite care.
Sexual Dysfunction	<ul style="list-style-type: none"> • For treatment of sexual dysfunction that is not related to organic disease or injury.
Skilled Nursing	<ul style="list-style-type: none"> • For skilled nursing facility services after you have reached the maximum level of recovery possible for your particular condition and no longer require definitive treatment other than routine supportive care; when confinement is intended solely to assist you with the activities of daily living or to provide an institutional environment for your convenience; or for treatment of substance abuse or mental illness.
Smoking (nicotine) Cessation	<ul style="list-style-type: none"> • For nicotine cessation support programs and/or classes.
Termination Date	<ul style="list-style-type: none"> • Incurred after the date of termination of your coverage except as provided herein.
Therapy	<ul style="list-style-type: none"> • For outpatient habilitative and rehabilitative services for which there is no expectation of acquiring, restoring, improving or maintaining a level of function.
TMJ	<ul style="list-style-type: none"> • For treatment of temporomandibular joint (jaw hinge) syndrome with intra-oral prosthetic devices, or any other method to alter vertical dimensions and/or restore or maintain the occlusion and treatment of temporomandibular joint dysfunction not caused by documented organic joint disease or physical trauma.
Transsexual Surgery	<ul style="list-style-type: none"> • For any treatment leading to or in connection with transsexual surgery, except for sickness or injury resulting from such

treatment or surgery.

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| Vision Correction Surgery | <ul style="list-style-type: none">• For the correction of myopia, hyperopia or presbyopia, including but not limited to corneal microsurgery, such as keratomileusis, keratophakia, radial keratotomy, corneal ring implants, Laser-Assisted in Situ Keratomileusis (LASIK) and all related services. |
| War | <ul style="list-style-type: none">• For losses sustained or expenses incurred as a result of an act of war whether declared or undeclared. |
| Weight Reduction | <ul style="list-style-type: none">• For weight reduction programs, including all diagnostic testing related to weight reduction programs, unless medically necessary and appropriate. |
| Well-Baby Care | <ul style="list-style-type: none">• For well-baby care visits, except as provided herein. |
| Workers' Compensation | <ul style="list-style-type: none">• For any illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any federal, state, or local government's workers' compensation, occupational disease or similar type legislation. This exclusion applies whether or not you claim the benefits or compensation. |

In addition, under your Prescription Drug benefits, except as specifically provided in this program or as Highmark is mandated or required to provide based on state or federal law, no benefits will be provided for:

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| Prescription Drugs
(Drug Program) | <ul style="list-style-type: none">• Services of your attending physician, surgeon or other medical attendant;• Prescription drugs dispensed for treatment of an illness or an injury for which the group is required by law to furnish hospital care in whole or in part—including, but not limited to—state or |
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federal workers' compensation laws, occupational disease laws and other employer liability laws.

- Prescription drugs to which you are entitled, with or without charge, under a plan or program of any government or governmental body.
- Charges for therapeutic devices or appliances (e.g., support garments and other non-medicinal substances).
- Charges for administration of prescription drugs and/or injectable insulin, whether by a physician or other person.
- Any charges by any pharmacy provider or pharmacist except as provided herein.
- Any drug or medication except as provided herein.
- Any amounts you are required to pay directly to the pharmacy for each prescription or refill.
- Charges for a prescription drug when such drug or medication is used for unlabeled or unapproved indications and where such use has not been approved by the Food and Drug Administration (FDA).
- Drugs and supplies that are not medically necessary and appropriate or otherwise excluded herein.
- Any amounts above the deductible, coinsurance, copayment or other cost-sharing amounts for each prescription order or refill that are your responsibility.
- Any prescription for more than the retail days supply or mail-service days supply as outlined in the Summary of Benefits.

- Any drug or medication which does not meet the definition of covered maintenance prescription drug.
- Over-the-counter drugs.
- Allergy serums.
- Hair growth stimulants.
- Food supplements.
- Immunizations/biologicals.
- Any drugs used to abort a pregnancy.
- Blood products.
- Antihemophilia drugs.
- Any drugs prescribed for cosmetic purposes only.
- Any prescription drug which has been disallowed under the Prescription Drug Management section of this booklet.
- Any drugs requiring intravenous administration, except insulin and other injectables used to treat diabetes.
- Any drugs which are experimental/investigative.
- Any drugs and supplies which can be purchased without a prescription order, including but not limited to blood glucose monitors and injection aids, unless specifically described as provided herein.
- Any prescription drugs or supplies purchased at a non-participating pharmacy provider, except in connection with emergency care described herein.
- Any prescription drug purchased through mail order but not

dispensed by a designated mail order pharmacy provider.

- Any selected diagnostic agents.