BENEFIT SUMMARY

FOR YOUR

HIGH DEDUCTIBLE HEALTH PLAN

WITH A

HEALTH SAVINGS ACCOUNT

PLAN YEAR

JANUARY 1, 2011 - DECEMBER 31, 2011

FOR

EMPLOYER NAME

Simplicity Health Plans

Simplicity Health Plans
HDHP with HSA
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This Benefit Summary is intended to provide You with an overview of coverage provided by Your Employer's Employee Health and Welfare Benefit Plan. This is a self-funded health plan. No right will accrue to You and/or Your eligible Dependents based on any statement in or omission from this summary. A detailed description of benefits, limitations, and exclusions can be found in the Summary Plan Description and Plan Document.

"In-Network" Services shall be paid at the **In-Network Maximum Allowed Amount (INMAA)*** which shall be either a percentage of the Medicare fee schedule as determined by the Plan Administrator or the negotiated PPO amount. The Member will only be responsible for any applicable Deductible and/or Co-payment.

"Out-of-Network" Services shall be paid at the **Out-of-Network Maximum Allowed Amount (ONMAA)**** which shall be a percentage of the Medicare fee schedule as determined by the Plan Administrator. If the Provider does not accept the Out-of-Network Maximum Allowed Amount as payment in full, then the Member may be responsible for the balance of the charges. ***"Out-of-Network"*** means that a Provider is not on the officially accepted PPO listing.

Plan Administrator Discounts The Plan Administrator reserves the right to negotiate on behalf of the Member for additional discounts with Providers for In-Network and Out-of-Network services. If a Provider agrees to the negotiated allowed amount, the Member will not be balance billed for the difference between what this Plan pays and the Provider charges. The Member will only be responsible for any applicable Deductible and/or Co-payment.

*****ALL PAYMENTS ARE SUBJECT TO THE MAXIMUM ALLOWED AMOUNT*****

Deductible & Out-of-Pocket Limit

PLAN YEAR DEDUCTIBLE (1)	OPTION #	SINGLE	FAMILY
One Plan Year Deductible Option will be selected by the Employer for this Plan. The Deductible will be the same for In-Network and Out-of-Network benefits and will apply to all eligible Members. **Amounts are per Plan Year.**	1	$1,200	$2,400
	2	$1,500	$3,000
	3	$2,000	$4,000
	4	$2,500	$5,000
	5	$3,050	$6,150
OUT-OF-POCKET LIMIT (OOPL) (2)	**All Options**	**$5,950**	**$11,900**

Benefits	In-Network*	Out-of-Network**
PREVENTIVE BENEFITS: (3) (12)	**Total of $350 Maximum per Single, $700 Maximum per Family, per Plan Year, In-Network.**	
Health Maintenance Exams & specific accompanying tests / procedures (13)	**Covered at 100% of INMAA**	**Not Covered**
Routine Pediatric Exams (well child care) (6)	**Covered at 100% of INMAA**	**Not Covered**
Routine immunizations, travel inoculations	**Covered at 100% of INMAA**	**Not Covered**
Routine Periodic Gynecological Exams & specific accompanying tests / procedures (Pap)	**Covered at 100% of INMAA**	**Not Covered**
Mammography	**Covered at 100% of INMAA**	**Not Covered**
PSA Screening (prostate)	**Covered at 100% of INMAA**	**Not Covered**
Colonoscopy Screening (6)	**Covered at 100% of INMAA**	**Not Covered**

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Benefits *continued*	In-Network*	Out-of-Network**
NON-PREVENTIVE BENEFITS		
Office visit when Sick or Injured	Covered 100% of INMAA after deductible	Covered 100% of ONMAA after deductible
Diagnostic Lab, X-Ray, Allergy Testing and Pathology (11)	Covered 100% of INMAA after deductible	Covered 100% of ONMAA after deductible
Allergy Test, Treatments and Injections	Covered 100% of INMAA after deductible	Covered 100% of ONMAA after deductible
Outpatient Facilities & Physician Benefits includes Surgery (7)	Covered 100% of INMAA after deductible	Covered 100% of ONMAA after deductible
Physical & Occupational Therapy (4)	Covered 100% of INMAA after deductible Maximum Benefit: 30 visits per Plan Year combined In-Network & Out-of-Network	Covered 100% of ONMAA after deductible
Speech Therapy (4)	Covered 100% of INMAA after deductible Maximum Benefit: 20 visits per Plan Year combined In-Network & Out-of-Network	Covered 100% of ONMAA after deductible
Chiropractic Office Visits (4) (5)	Covered 100% of INMAA after deductible Maximum Benefit: Not to exceed $30 per visit, 2 visits per month per Plan Year, combined In-Network & Out-of-Network	Covered 100% of ONMAA after deductible
Cardiac Rehabilitation (4)	Covered 100% of INMAA after deductible Maximum Benefit: 6 weeks maximum within 60 consecutive days combined In-Network & Out-of-Network. This treatment may include up to 3 weeks with ambulatory monitoring of heart rate and rhythm.	Covered 100% of ONMAA after deductible
Home Health Care (9) (4)	Covered 100% of INMAA after deductible Maximum Benefit: 60 visits per Plan Year combined In-Network & Out-of-Network	Covered 100% of ONMAA after deductible
Skilled Nursing Care / Extended Care (9) (4)	Covered 100% of INMAA after deductible Maximum Benefit: Not to exceed $500 per day, 30 days per Plan Year combined In-Network & Out-of-Network	Covered 100% of ONMAA after deductible
Hospice Care (9) (10) (4)	Covered 100% of INMAA after deductible See (10) for Limits	Covered 100% of ONMAA after deductible
Durable Medical Equipment, Prosthetic & Orthotic Devices (9)	Covered 100% of INMAA after deductible	Covered 100% of ONMAA after deductible
Infertility Assessment	Covered 100% of INMAA after deductible	Covered 100% of ONMAA after deductible
Maternity & Pre/Post Natal Care	Covered 100% of INMAA after deductible	Covered 100% of ONMAA after deductible

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Benefits *continued*	In-Network*	Out-of-Network**
EMERGENCY & URGENT CARE	**Emergency Care is covered at any hospital emergency room. Additional charges for Out-of-Network may apply.**	
Emergency Care	Covered 80% of INMAA after deductible	Covered 80% of ONMAA after deductible
Urgent Care Facility	Covered 100% of INMAA after deductible	Covered 100% of ONMAA after deductible
Ambulance Transportation	Covered 100% of INMAA after deductible	Covered 100% of ONMAA after deductible
INPATIENT HOSPITAL BENEFITS		
Days of Care	Subject to Plan Year & Lifetime Maximum (LTM)	Subject to Plan Year & Lifetime Maximum (LTM)
Room Type	Semi-private, Private when Medically Necessary	Semi-private, Private when Medically Necessary
Hospital Services/ Admissions (9)	Covered 100% of INMAA after deductible	Covered 100% of ONMAA after deductible
Physician Services	Covered 100% of INMAA after deductible	Covered 100% of ONMAA after deductible
Organ & Tissue Transplants (9)	Covered 100% of INMAA after deductible	Not Covered
Maternity, including routine newborn services	Covered 100% of INMAA after deductible	Covered 100% of ONMAA after deductible
MENTAL HEALTH CARE	**Covered 100% of INMAA after deductible**	**Covered 100% of ONMAA after deductible**
Includes Mental Disorders, Inpatient (4) & Outpatient (4)	**Maximum Benefit:** Limited to 15 days inpatient per Plan Year combined In-Network & Out-of-Network Limited to 30 days outpatient per Plan Year combined In-Network & Out-of-Network	
Substance Abuse, Alcohol & Chemical Dependence Inpatient (4) & Outpatient (4)	**Maximum Benefit:** Limited to 5 days inpatient per Plan Year combined In-Network & Out-of-Network Limited to 15 days outpatient per Plan Year combined In-Network & Out-of-Network	

Benefits *continued*	In-Network*	Out-of-Network**
PRESCRIPTION DRUGS		
Prescriptions (8) **Pharmacy and Medical Benefits are covered under the same Plan Year Deductible. After the Deductible is satisfied, Generic Drugs will be subject to a $10 Co-payment per prescription/refill and Brand Drugs will be subject to a $25 Co-payment per prescription/refill. Prescription Co-payments count toward the Out-of-Pocket Limit and will cease when the Out-of-Pocket Limit is met. When You have prescriptions filled at a pharmacy that is not a Member Pharmacy, You must pay for the prescription in full and then follow the instructions for filing a claim. You will be reimbursed at the Maximum Allowed Amount that would have been paid to a Member Pharmacy *(a pharmacy which participates in the pharmacy network of this Plan)* for the cost of the drug minus any applicable Deductible and/or Co-payment.** **Brand & Generic Substitution Program** ***The Plan does not cover the difference between the cost of a Generic Drug and a Brand Drug when a Generic is available. The Plan Member is responsible for paying any applicable Deductible and Co-payment in addition to the price difference between the Generic and Brand name product when a Generic equivalent is available.***		
OTHER BENEFITS		
Vision		***Per Plan if applicable***
Dental		***Per Plan if applicable***
PLAN YEAR MAXIMUM	**$1 MILLION PLAN YEAR MAXIMUM per Member for all covered benefits**	
LIFETIME MAXIMUM (LTM)	**UNLIMITED LIFETIME MAXIMUM per Member for all covered benefits**	

FOOTNOTES

(1) **Plan Year Deductible:** The amount of money a Member must pay for covered benefits before the Employer's Employee Health and Welfare Benefit Plan becomes responsible for payment. For Members with pharmacy benefits provided through the Plan, the Deductible includes both medical and pharmacy expenses. The Deductible does not apply to some preventive services. The Deductible is applied once per Your Employer's Plan Year. Each Plan Year begins a new Deductible period. If You have Family coverage, there is no single Deductible for each Family Member and the entire Family Deductible must be met before the Plan becomes responsible for payment for any individual Member in the Family. Amounts for non-covered services do not count toward a Member's Deductible or Out-of-Pocket expense limits. The difference between the Plan's Out-of-Network Maximum Allowed Amount and the Provider charges for services received Out-of-Network does not count toward a Member's Deductible or Out-of-Pocket expense limits.

(2) **Out-of-Pocket Limit (OOPL):** The total amount of Deductibles and Co-payments that a Member and Member's eligible Dependents must pay for services during any Plan Year. Amounts for non-covered services do not count toward a Member's OOPL. The difference between the Plan's Out-of-Network Maximum Allowed Amount and the Provider charges for services received Out-of-Network does not count toward a Member's Deductible or Out-of-Pocket expense limits. Members remain responsible for emergency care Co-payments and for the cost of non-covered services even after the OOPL is met.

(3) **Preventive Benefits:** Covered at 100% In-Network up to a total maximum for all specific Preventive Benefits of $350 per Single coverage per Plan Year or $700 per Family coverage per Plan Year. Once the maximum is reached, eligible benefits will be covered subject to the Deductible. Charges for Colonoscopy Screenings do not apply toward the Plan Year Preventive Benefits maximum and are not subject to the Deductible. Please refer to the Summary Plan Description and Plan Document for current listing, by CPT Code, of specific Preventive Benefits eligible under this Plan.

FOOTNOTES *continued*

(4) Any visits paid for by the Member and applied to the Deductible are also applied to the maximum benefit limits. Once the maximum benefit limit is reached, a service is no longer a covered service.

(5) **Chiropractic Office Visits:** This Plan only covers the office visit charges. Charges for related labs, x-rays and any other services are excluded.

(6) **Age and/or frequency limits apply:** **Well Child Care:** 6 Visits per Plan Year up to age 2. From age 2 forward, one visit per Plan Year for eligible Dependent children. **Colonoscopy Screening:** Colonoscopy Screenings are limited to one every ten years beginning at age 50.

(7) Please refer to the Summary Plan Description and Plan Document for a complete listing of all non-emergency surgeries, benefits, services and supplies that require Pre-authorization and Second Opinions in order to be covered under this Plan.

(8) If a nonparticipating pharmacy is used, You must pay 100% of the actual charges and file a claim for processing.

(9) Pre-authorization required in order to be eligible for these benefits. Please refer to the Summary Plan Description and Plan Document for a complete listing of all benefits, services and supplies which require pre-authorization. Call (877) 747-1113 for Pre-authorizations.

(10) Counseling for the hospice patient and immediate Family is limited to 15 visits per Family per Lifetime. Medical Social Services limited to $100 per Family per Lifetime.

(11) Does not apply to preventive/routine care. Non-Covered services if performed as routine care.

(12) Preventive Benefits paid by the Employer at any percent are not counted towards the Deductible.

(13) Health Maintenance Exams are limited to one per Plan Year.

(14) To be covered, expenses must be Medically Necessary and specified as covered. Please see Your Summary Plan Description and Plan Document for more information on medical necessity and other specific Plan benefits.

PRE-EXISTING CONDITIONS LIMITATION

If an otherwise Eligible Employee or Dependent enrolls for coverage under the Plan after the Effective Date of this Plan, the Covered Person shall not be entitled to benefits for expenses incurred as the result of Injuries or illnesses for which the Covered Person has consulted with a Physician, taken medication or received any Medical Care or services within a six (6) month period immediately prior to his Enrollment Date until the expiration of a period of twelve (12) consecutive months from the Covered Person's Enrollment Date in the Plan. This Pre-Existing Conditions Limitation provision does not apply to a newborn child enrolled within thirty (30) days of his/her birth, or to an adopted child under age eighteen (18) who is enrolled within thirty (30) days of his/her adoption or placement for adoption, or to expenses due to Pregnancy which would otherwise have been eligible for benefits under the Plan.

Any period of time during which Creditable Coverage, as defined, was in effect will carry over to offset or reduce the Pre-Existing Conditions Limitation of twelve (12) months as long as no break in coverage of sixty-three (63) days or more has occurred. Any Waiting Period for coverage is not considered a break in coverage. Certification of Creditable Coverage must be supplied indicating the exact time period such coverage was in effect. The employer, insurance company or other organization under which the Creditable Coverage occurred supplies this certification.

Furthermore, a Pre-Existing Condition is also a Sickness or Injury which was diagnosed or treated, or which produced signs or symptoms that would cause an ordinary, prudent person to seek treatment, during the six (6) month period before the Covered Person's effective date of coverage. Benefits for Pre-Existing Conditions are not payable until the Covered Person's coverage has been in force for twelve (12) consecutive months with this Employer's Employee Health and Welfare Benefit Plan.

OTHER EXPENSES NOT COVERED

Unless stated otherwise in the Summary Plan Description and Plan Document, no benefits are payable for expenses arising from:

1. Expenses incurred before the effective date or after the date coverage terminated.
2. Services not Medically Necessary or which are Experimental, Investigational or for research purposes.
3. Services while confined in a Hospital or other facility owned or operated by the United States government, provided by a person who ordinarily resides in the Covered Person's home or who is a family member, or that are performed in association with a service that is not covered under the Plan.
4. Charges incurred for which the Plan has no legal obligation to pay.
5. Charges caused by war, declared or undeclared, or any act of war.
6. Charges incurred while on full-time active duty in the armed forces of any country, combination of countries, or international authority.
7. Injury or Sickness arising out of or in the course of any occupation, employment or activity for compensation, profit or gain, whether or not benefits are available under Workers' Compensation. This exclusion does not apply to a Covered Person qualifying as a sole proprietor, officer or partner under state law, and such benefits are not covered under any Workers' Compensation plan, provided the Covered Person is not covered under a Workers' Compensation plan, except for certain professions or activities as stated in the Plan.
8. Care and treatment for which there would not have been a charge if no coverage had been in force.
9. Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.
10. Charges in excess of the Maximum Allowed Amount or which exceed any maximum Plan benefit.
11. Any loss due to attempted suicide or intentionally self-inflicted Injury when sane.
12. Care or treatment resulting from the voluntary taking of or while under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for injured Covered Persons other than the person using controlled substances.
13. Services not authorized or prescribed by a health care practitioner or for which no charge is made.
14. Charges resulting from or occurring during the commission of a crime by the Covered Person, or while engaged in an illegal act, illegal occupation, aggravated assault, or participating in a riot or public disturbance.
15. Charges incurred for Experimental procedures, drugs, or research studies, or for any services or supplies not considered legal in the United States. Any drug, medicine or device that is not FDA approved.
16. Charges incurred for drugs, devices, medical treatments or procedures that have not received the approval or endorsement of the American Medical Association (AMA) for the specific Injury or illness to be treated.
17. Charges incurred for drugs, devices, medical treatments or procedures that have not received the approval or endorsement of the National Institutes of Health (NIH) or its affiliated institutes for the specific Injury or illness to be treated.
18. Contraceptives other than oral, including implant systems and devices regardless of the purpose for which prescribed.
19. Medications, drugs or hormones to stimulate growth.
20. Charges related to or in connection with fertility studies, sterility studies, procedures to restore or enhance fertility, artificial insemination, or in-vitro fertilization or charges resulting from or in connection with the sterilization or reversal of a sterilization procedure.
21. Care, services, or treatment for transsexualism, gender dysphoria or sexual reassignment or change, including medications, implants, hormone therapy, surgery, medical or psychiatric treatment.
22. Any surgical procedure for the correction of a visual refractive problem, including radial keratotomy. Lenses for the eyes and examinations for their fitting. This exclusion does not apply to aphakis patients and soft lenses or sclera shells intended for use as corneal bandages.
23. Vision therapy; all types of refractive keratoplasties or any other procedures, treatments or devices for refractive correction; eyeglasses; contact lenses. Hearing aids and examinations for their fitting.
24. Dental services (except for dental Injury), appliances or supplies.

OTHER EXPENSES NOT COVERED *continued*

Unless stated otherwise in the Summary Plan Description and Plan Document, no benefits are payable for expenses arising from:

25. Cosmetic dentistry. Dental services or x-ray examinations involving one or more teeth, the tissue or structure around them, the alveolar process or the gums. All diagnostic and treatment services related to the treatment of jaw joint problems, including temporomandibular joint syndrome in excess of $1,500.00 for any Plan Year. This exclusion does not apply to charges made for treatment or removal of a malignant tumor, for treatment of conditions directly related to underlying medical and surgical procedures for which this Plan has provided coverage, or for the following dental services received within twelve (12) months after an accident: treatment by a doctor, dentist or dental surgeon for Injuries to natural teeth including replacement of such teeth and related x-rays.
26. Routine or periodic examinations, screening examinations, evaluation procedures, preventive Medical Care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness, or Pregnancy-related condition, unless such care is specifically covered in the Schedule of Benefits. Routine physical examinations for occupation, employment, school, travel, purchase of insurance or premarital tests are excluded.
27. Services or supplies provided mainly as a rest cure, maintenance, or Custodial Care.
28. Any treatment for the purpose of reducing obesity, or any use of obesity reduction procedures to treat Sickness or Injury caused by, complicated by, or exacerbated by obesity, including but not limited to surgical procedures.
29. Charges for treatment of nicotine habit or addiction; expenses incurred for educational or vocation therapy, services and schools; light treatment for Seasonal Affective Disorder (S.A.D.); alternative medicine; marital counseling; genetic testing, counseling or services; sleep therapy or services rendered in a premenstrual syndrome clinic or holistic medicine clinic.
30. Care and treatment for hair loss, including hair prosthesis, implants, wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician. Wigs will be covered if the hair loss is directly related to underlying medical and surgical procedures for which this Plan has provided coverage.
31. Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan. Charges for health clubs or health spas, aerobic and strength conditioning, work hardening programs and related material and products for these programs; personal computers and related or similar equipment; communication devices other than due to surgical removal of the larynx or permanent lack of function of the larynx.
32. Care and treatment of an Injury or Sickness that results from engaging in a Hazardous Hobby. A hobby is hazardous if it is an unusual activity, which is characterized by a constant threat of danger or risk of bodily harm. Examples of hazardous hobbies are horseback riding, skydiving, auto racing, hang gliding, and bungee jumping.
33. Services, supplies, care or treatment in connection with an abortion, unless the life of the mother is endangered by the continued Pregnancy or the Pregnancy is the result of rape or incest.
34. Charges for elective medical or surgical procedures; sterilization, including tubal ligation and vasectomy; reversal of sterilization; gender change or sexual dysfunction.
35. Care and treatment, which has not been pre-authorized, billed by a Hospital for non-emergency admissions. This does not apply if surgery or significant treatment as prescribed by an attending Physician is performed within 24 hours of admission.
36. Charges for standby Physician or assistant surgeon, unless Medically Necessary; private duty nursing; communication or travel time; lodging or transportation, except as stated in the Plan.
37. Charges for non-medical purposes or used for environmental control or enhancement (whether or not prescribed by a health care practitioner). Any personal comfort items, elective expenses, or other equipment, such as, but not limited to: air conditioners, humidifiers, blood pressure instruments, scales, shoes, inserts, ankle pads, printed material, arch supports, elastic stockings, fluoride, vitamins, nonprescription drugs, nutritional or dietary counseling, or food supplements.
38. Blood or blood plasma that is replaced on a discretionary basis by or for the patient. This exclusion in no way limits the coverage for blood or blood plasma used in a covered procedure.
39. Expenses applied toward satisfaction of the Deductible.
40. Routine foot care services and services performed by a podiatrist. Treatment of weak, strained, flat, unstable, or unbalanced feet, metatarsalgia, or bunions, except open cutting operations. Charges for corns, calluses, or toenails, except the removal of nail roots and necessary services in the treatment of metabolic or peripheral-vascular disease.

OTHER EXPENSES NOT COVERED *continued*

Unless stated otherwise in the Summary Plan Description and Plan Document, no benefits are payable for expenses arising from:

41. Cosmetic procedures and any related complications, except cosmetic surgery for: (1) charges to repair or alleviate damage incurred within two years of an accident; (2) surgery to restore bodily function or to correct deformity resulting from a disease, trauma, congenital birth defects, or previous therapeutic process; or (3) reconstructive surgery following a mastectomy.
42. Organ transplants not approved based on established criteria or Investigational, Experimental or for research purposes. Organ transplants except as allowed in the Covered Charges and Schedule of Benefits sections.
43. Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.
44. Care or treatment for which there would have been no benefit Plan issued or benefits available if complete details and information would have been disclosed at the time of the original Employee and Employer's Questionnaires/Applications. Any material misrepresentation provided for underwriting and stop loss/excess loss insurance/reinsurance in the Questionnaires/Applications could cause the cancellation of the stop loss/excess loss policy/treaty purchased and issued to the Trust.
45. Services received in an emergency room unless required because of emergency care.
46. Inpatient services when in an observation status or when the stay is due to behavioral, social maladjustment, lack of discipline or other antisocial actions not a result of a Mental Disorder.
47. Charges incurred for a Hospital stay beginning on a Friday or Saturday unless due to emergency care or surgery is performed on the day admitted.
48. Charges covered by another plan sponsor or payor.
49. Charges incurred as a result of radioactive contamination or the hazardous properties of nuclear material.

In addition to "OTHER EXPENSES NOT COVERED", covered outpatient prescription drug charges DO NOT INCLUDE any charges:

1. For drugs prescribed for a Pre-Existing Condition or for drugs covered under another plan sponsor or payor.
2. For drugs prescribed for care, services or treatment which are not covered medical charges, or for drugs determined to be not Medically Necessary as determined by the Plan.
3. For drugs not listed as formulary medications in the Drug Formulary or as preferred medications on the Plan's preferred drug list.
4. For drugs administered or dispensed by a Physician, a Hospital, rest home, sanitarium, extended care facility, convalescent care facility, nursing home facility or similar institution.
5. For infertility drugs, regardless of intended use, or for any drugs used in the treatment of infertility or to facilitate Pregnancy.
6. For over-the-counter ("OTC") drugs available without a prescription (other than injectable insulin); and for drugs that the Plan determine have one or more over-the-counter equivalents or contain the same active ingredient(s) as over-the-counter medication.
7. Drugs available in prescription strength without a prescription EXCEPT AS NOTED AS TIER 1 DRUGS.
8. For compounded medications not containing all covered active ingredients; for Combination drugs or drug products manufactured and/or packaged together and containing one or more not-covered active ingredients; drugs prescribed by a dentist or prescribed for dental services and unit-dose drugs.
9. For injectable drugs which the Plan does not authorize to be paid under this benefit and the administration or injection of any drug.

Outpatient prescription drug charges DO NOT INCLUDE any charges: *continued*

10. For drugs limited by federal law to Investigational use; drugs used experimentally or investigationally; Experimental or Investigational drugs, even when a charge is made; drugs with no U.S. Food and Drug Administration ("FDA") approved indications for use, FDA approved drugs used for indications, dosage or dosage regimens or administration outside FDA approval, and drugs determined by the FDA as lacking in substantial evidence of effectiveness for a particular condition, disease, or for symptom control.
11. Drugs prescribed for intended use other than for indications approved by the FDA or recognized off-label indications through peer-review medical literature or by the commissioner.
12. For immunization agents, biological sera, blood, blood plasma or other blood products, self-injectables or other prescriptions requiring parental administration or use, except insulin or Imitrex.
13. For nonprescription supplements, dietary products, vitamins and minerals other than legend prenatal vitamins prescribed during Pregnancy.
14. For prescriptions refilled in excess of the number specified by the Physician's original order.
15. For prescriptions dispensed after one year from the Physician's original order.
16. For drugs delivered or administered by the prescriber; take-home prescriptions.
17. For any drug used for Cosmetic purposes as determined by Us, for growth hormone and its derivatives; for any drug used to stimulate or to promote growth; botulinum toxin and its derivatives; or onychomycosis (nail fungus). For drugs used in the treatment of chronic fatigue or related syndromes or conditions.
18. For herbal or homeopathic medicines or products, and nutraceuticals.
19. For Retin-A (tretinoin) and other drugs used in the treatment or prevention of acne or related conditions for a Covered Person age thirty (30) and older.
20. For medications used to treat, impact or influence "quality of life" or "lifestyle" concerns including but not limited to: smoking deterrence or cessation; obesity; weight management; prevention or treatment of hair loss; prevention or treatment of excessive hair growth or abnormal hair patterns, sexual function, dysfunction, performance or inadequacy; conscious or unconscious sexual energy or desire; skin coloring or pigmentation; social phobias; slowing the normal processes of aging; memory improvement or cognitive enhancement, daytime drowsiness, overactive bladder, athletic performance, body conditioning, strengthening, or energy; drymouth, excessive salivation, or hyperhidrosis (excessive sweating).
21. For DDAVP (desmopressin acetate) or other drugs used in the treatment of nocturnal enuresis (bedwetting) for a Covered Person under the age of eight; for drugs used to treat hyperactivity, attention deficit and related disorders.
22. For drugs in connection with an accidental Injury or illness that arises out of, or is the result of, any work for wage or profit; except that this exclusion will not apply to:
    a. The sole proprietor, if the Employer is a proprietorship; or
    b. A partner of the Employer, if the Employer is a partnership; or
    c. An executive officer of the Employer, if the Employer is a corporation;
    d. for any such charges that result from accidental Injury or illness that arises out of or is a result of any work for the Employer and then only if he or she is not required to have coverage under any Workers Compensation Act or similar law and does not have such coverage.
23. For drugs used for outpatient care for the treatment of Mental Disorder in excess of the limits reflected in the covered outpatient prescription drugs charges section; for other drugs or drug categories with limited coverage, when used in excess of the limits.
24. For charges in excess of the Generic Drug prescription.
25. For more than the Plan determines to be an average quantity of medication required to treat an immediate condition or symptom on an "as needed" basis or which the Plan determines to be excessive in scope, duration or intensity of drug therapy needed for safe, adequate and appropriate care.
26. For prescriptions, dosages or dosage forms issued principally for the convenience of the Covered Person or the Covered Person's family or Physician.
27. For duplicate prescriptions, replacement of lost, stolen, destroyed or damaged prescriptions or prescriptions refilled more frequently than the prescribed dosage indicates.

Outpatient prescription drug charges DO NOT INCLUDE any charges: *continued*

28. For drugs designed or used to diagnose, treat, alter, impact, or differentiate a Covered Person's genetic make-up or genetic predisposition unless specifically authorized by the Plan for a specified period of time under a medical plan and medical plan provisions.
29. For any drug payable under the medical benefit portions of this Plan.

ADDITIONAL PROVISIONS

Drugs and medicines, which are covered under this outpatient prescription drug benefit, will be excluded under any medical benefits for which You are also covered under this Plan. Any drug which is a metabolite, isomer, extended release or other dosage form, or other direct or indirect derivative of a drug approved by the FDA may be subject to similar terms, limitations and conditions of coverage or non-covered by the Plan as the original drug.

Charges which are payable under the medical benefit portions of the Plan are not payable under the outpatient prescription drug benefit. No benefits are payable under this benefit section for charges incurred on or after the date Your Plan and/or outpatient prescription drug benefits terminate.

If the Plan determines that You or Your covered Dependent(s) are engaged in activities that could be deemed inappropriate or misuse of services, We reserve the right to terminate Your coverage under the Plan. Alternatively, We reserve the right to limit covered outpatient services to a single pharmacy to help ensure the quality provision of services for You and Your covered Dependents.

FOR MORE INFORMATION

Simplicity Health Plans Website

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