COVENTRY HEALTH CARE OF NEBRASKA, INC.
CoventryOne Schedule of Benefits

Nebraska 500 (C502)	In Network Preferred Benefits	Out-of-Network
Physician Office Services : (Family Practice, General Practice, Internal Medicine, Pediatrics) • Physician office visits for routine physical, injury, or sickness • Pediatric and Well Child Care including immunizations • Diagnostic X-ray and laboratory (in Physicians Office)	$20 Copayment	Deductible and Coinsurance
Specialty Physician Office Services: • Specialty Physician office visits for routine physical, injury, or sickness • Diagnostic X-ray and laboratory (in Physicians Office)	$40 Copayment	Deductible and Coinsurance
Inpatient Hospital Services • Unlimited Hospital Days (Semi-Private Room and Board) • Private Room and Board when Medically Necessary • Professional Services • Medications and Drugs • X-ray and Laboratory • Intensive/Coronary Care • Radiation Therapy • Administration of Blood	Deductible and Coinsurance	*Deductible and Coinsurance
Transplants *(When performed at a Coventry Transplant Network Facility approved by CHC)*	Deductible and Coinsurance	No Out-of-Network Benefit
Outpatient Hospital Services • X-ray and Laboratory • Ambulatory Surgery	Deductible and Coinsurance	*Deductible and Coinsurance
Short Term Therapies For maximum benefit coverage all services require prior authorization • Speech and Occupational Therapy.** • Physical Therapy (does not require prior authorization).** • Cardiac Rehabilitation and Pulmonary Rehabilitation (combined visit maximum of 36 visits per contract year).	Deductible and Coinsurance	*Deductible and Coinsurance
Other Therapies • Manipulative Therapy (combined visit maximum of 20 visits per contract year)	$25 Copayment	*Deductible and Coinsurance
Nursing Facility For maximum benefit coverage all services require prior authorization Limited to 60 days per contract year	Deductible and Coinsurance	*Deductible and Coinsurance
Home Health Care For maximum benefit coverage all services require prior authorization Limited to 60 days per contract year	Deductible and Coinsurance	*Deductible and Coinsurance
Hospice For maximum benefit coverage all services require prior authorization	Deductible and Coinsurance	*Deductible and Coinsurance
Prosthetic Devices and DME For maximum benefit coverage all services require prior authorization. Limited to $2,500 per contract year.	Deductible and Coinsurance	*Deductible and Coinsurance
Urgent care center • At an Urgent Care Facility	$40 Copayment	Deductible and Coinsurance

Emergency Health Services • Hospital emergency room • Ambulance Ground transportation Air transportation	\$100 Copayment and 20% Coinsurance \$100 Copayment	\$100 Copayment and 20% Coinsurance \$100 Copayment
Deductible (Per Contract Year) • Individual • Family (Aggregate)	\$500 \$1,000	\$1,000 \$2,000
Coinsurance (Per Contract Year)	20%	40%
Out-of-Pocket Maximum: • Individual • Family (Aggregate)	\$2,000 \$4,000 Only the **deductible** and **coinsurance** apply to the out-of-pocket maximum by accumulating any combination of those amounts under the care directed by any participating provider as well as the self – referral and out-of-network benefits.	\$4,000 \$8,000
Maximum Benefit:	Unlimited	\$5,000,000

Note: Copays do not apply to the Out-of-Pocket Maximum. Flat dollar copays are not subject to the deductible. Failure to request prior authorization when and as required may result in reduced benefits and in some instances, benefits may be denied. Out-of-Pocket contributions may also be reduced or denied.

* Services where prior authorization is the covered member's responsibility.

** Speech, Occupational and Physical therapies have a combined visit maximum of 20 visits per contract year.

Exclusions & Limitations

Services not covered include: services that are not medically necessary; personal or convenience items; custodial care; cosmetic services and surgery; over-the-counter drugs and medications not requiring a prescription; experimental procedures and treatments; and food or food supplements. For maximum benefit coverage all services, except in the case of a Medical Emergency and Out-of-Area Urgent Care, should be rendered or authorized by Participating Providers.

Members are required to obtain prior authorization for planned hospital admissions and for elective surgeries. Contact Coventry Health Care of Nebraska, Inc. prior to a hospital admission or elective surgery. A penalty of 20% of the Out-of-Network Rate will apply if you do not prior authorize a planned hospitalization. Penalties do not apply towards the out-of-pocket-maximum.

This Schedule is part of Your Evidence of Coverage (EOC) but does not replace it. Many words are defined elsewhere in the EOC and other limitations or exclusions may be listed in other sections of your EOC. Reading this Schedule by itself could give you an inaccurate impression of the terms of Your Coverage. This Schedule must be read with the rest of Your EOC. A complete list of Covered Services, Exclusions, and Limitations can be found in Your EOC.

Rider for Prescription Drugs
This Rider is issued to the Subscriber on the Effective Date and made a part of the Evidence of Coverage to which it is attached. The benefits provided by this Rider become effective for the Subscriber and his/her Dependents on their respective Effective Dates.

Coventry Health Care of Nebraska, Inc., is hereafter called the "Health Plan", "We", "Us", or "Our".

Any subscriber, or dependent, or qualified beneficiary who enrolled for Coverage under the Certificate of Coverage in accordance with its terms and conditions is hereafter called "You" or "Member".

The Copayment for Prescription Drugs is as follows:

Participating Pharmacy	Non-Participating Pharmacy
$10 for Formulary generic medications; $30 for Formulary brand name medications; or $55 for Non-Formulary Prescription Drugs.	*Deductible and **Coinsurance

The Copayment for Self-Administered Injections is as follows:

Participating Pharmacy	Non-Participating Pharmacy
$10 for Formulary generic Self-Administered Injections; $30 for Formulary brand Self-Administered Injections; or $55 for Non-Formulary Self-Administered Injections.	*Deductible and **Coinsurance

*Deductible: Individual $500 Family $1,000
**Coinsurance: 50%

ARTICLE 1. DEFINITIONS

Any capitalized terms used in this Rider and not otherwise defined herein shall have the meaning set forth in the Evidence of Coverage. The following definitions apply to this Rider:

Ancillary Charge
A charge which the Member is required to pay to a Participating Pharmacy for Prescription Drugs when a Member requests, or Member's physician prescribes as "brand name only" or otherwise directs, that a Non-Formulary or Formulary brand name drug be dispensed for which there is a Formulary or an FDA approved generic drug. The Ancillary Charge, if any, shall be the difference between the Non-Formulary or Formulary brand name drug and Our contracted price, or Maximum Allowable Cost if applicable, for the generic drug. The Member is responsible at the time of service for payment of the Ancillary Charge directly to the Participating Pharmacy. The Ancillary Charge is in addition to the Prescription Drug Deductible and Copayment amounts.

Copayment
The amount that will be charged to the Member by the Pharmacy to dispense or refill any Prescription Order. The Member is responsible at the time of service for payment of the Copayment directly to the Pharmacy.

Prescription Drug Coinsurance
The percentage amount of Eligible Charges that will be paid by the Health Plan after any Deductible or Copayment has been deducted from the Eligible Charges. Coinsurance percentage amounts are set forth in this rider.

Covered Drugs
Prescription Drugs prescribed by a Prescribing Provider and approved by Us subject to Articles 2, 3, and 4 of this Rider.

Prescription Drug Deductible
The annual Prescription Drug Deductible, which must be, satisfied each Calendar Year before a Member or Family, if applicable, may receive benefits under this Rider. Prescription Drug Deductible will not carry over to the next Contract Year. The dollar amount applied to Your deductible is based on the dollar amount that We pay Participating Pharmacies for filling a prescription.

Formulary
A listing of Prescription Drugs which are approved for use by Us and which will be dispensed through a Pharmacy to Members. This list shall be subject to periodic review and modification by Us. The Formulary is available for review in the searchable Formulary on our website, in the Prescribing Provider's office, or by contacting Our Customer Services Department (the phone number can be found on your membership card).
The Formulary may include only one (1) brand on Our Formulary when the same drug is made by two (2) different manufacturers.

Experimental Drugs
Pharmacological regimens not generally accepted or supported by peer-reviewed literature, or by the medical community, or the Food and Drug Administration and approved by Us.

Maximum Allowable Cost (MAC)
The price assigned to Prescription Drugs that will be covered at the generic product level, subject to periodic review and modification by the Health Plan.

Maintenance Medications
Those Prescription Drugs that are prescribed for long-term or chronic conditions such as high blood pressure or diabetes, and designated by Us as Maintenance Medications on our Mail Order List.

Medically Necessary
Medically Necessary services and/or supplies provided to a Member are those determined by the Health Plan to be:

i. Medically appropriate, so that the expected health benefits (such as, but not limited to, increased life expectancy, improved functional capacity, prevention of complications, relief of pain) materially exceed the expected health risks;
ii. Necessary to meet Your health, improve physiological function and required for a reason other than improving appearance;
iii. Rendered in the most cost-efficient manner and setting appropriate for the delivery of the health service;
iv. Consistent in type, frequency and duration of treatment with scientifically-based guidelines of national medical research, professional medical specialty organizations or governmental agencies that are accepted by the plan as national authorities on the services, supplies, equipment or facilities for with coverage is requested;
v. Consistent with the diagnosis of the condition at issue;
vi. Required for reasons other than Your comfort or the comfort and convenience of Your physician; and,
vii. Not Experimental or Investigational as determined by Us under our Experimental Procedures Determination Policy (A copy of the Experimental Procedures Determination Policy is available upon request from our Member Services Department.)

Non-Formulary Drugs
Prescription Drugs not listed on the Formulary.

Non-Participating Pharmacy
Any registered, licensed pharmacy with which We have not contracted.

Participating Pharmacy
Any registered, licensed pharmacy, or Mail Order Pharmacy approved by the plan with which We have contracted to dispense Prescription Drugs to Members.

Mail Order Pharmacy
When applicable, the Participating Pharmacy contracted by Us to provide Maintenance Medications through the mail.

Prescribing Provider
Any person holding the degree of Doctor of Medicine, Doctor of Osteopathy, Doctor of Dental Medicine, or Doctor of Dental Surgery, or any other provider who is duly licensed in the United States to prescribe medications in the ordinary course of his or her professional practice.

Prescription Drug
A drug which has been approved by the Food and Drug Administration for the specific use and which can, under federal or state law, be dispensed only pursuant to a Prescription Order (i.e., a legend medication) and has not been excluded under Articles 3 or 4 of this Rider. Prescription Drug shall include Self-Administered Injectable Drugs, diabetic supplies (insulin syringes, with or without needles, needles, blood and urine glucose test strips, lancets and devices, ketone test strips and tabs).

Prescription Order or Refill
The authorization for a legend Prescription Drug issued by a Prescribing Provider who is duly licensed to make such an authorization in the ordinary course of his or her professional practice.

Prior Authorization (PA)
A process where Our designee or We determine, prior to dispensing, that a Prescription Order or Refill, otherwise Covered under this Rider, has been reviewed and, based upon information provided by the Prescribing Provider, the Prescription Order or Refill satisfies Our requirements for Coverage.

Self-Administered Injectable Drugs
Self-Administered Injectable Prescription Drugs are Prescription Drugs, as defined by the Health Plan, that are commonly and customarily administered by the Member, and are dispensed only by the Specialty Pharmacy, or other Pharmacy designated by the Health Plan. Other self-administered injectable drugs, that are acquired through the Retail Pharmacy, are not considered Self-Administered Injectable Prescription Drugs, such as: injectable diabetes agents (such as insulin and glucagon), bee sting kits, Imitrex and injectable contraceptives. Examples of Self-Administered Injectable Prescription Drugs include but are not limited to the following: multiple sclerosis agents, growth hormones, colony stimulating factors given more than once monthly, chronic medications for hepatitis C, certain rheumatoid arthritis medications, certain injectable HIV drugs, certain osteoporosis agents, and heparin products.

Self-Administered Injectable Drug Copayment
The amount that will be charged to You by the Specialty Pharmacy to dispense or refill any Prescription Order or Refill for a Self-Administered Injectable Drug. You shall be required to pay one (1) Self-Administered Injectable Drug Copayment per each Prescription Order or Refill. You are responsible for payment of the Self-Administered Injectable Drug Copayment directly to the Specialty Pharmacy at the time of service.

Specialty Pharmacy
A pharmacy that directly or indirectly has a contract with the Health Plan and is designated as a Specialty Pharmacy by the Health Plan for certain Prescription Orders or Refills.

Usual and Customary Charge
The dollar amount charged by the pharmacy to a cash customer.

ARTICLE 2. Prescription Drug Benefit

Subject to Articles 3 and 4 of this Rider, benefits under this Rider shall be available for Covered Drugs pursuant to a Prescription Order for the outpatient use of the Member, as described below.

The Health Plan may in certain circumstance make some over-the-counter drugs available to Members under the terms of this Rider. Such over-the-counter drugs will be listed on the Formulary. The Copayment will be determined by the Health Plan as set forth below.

2.0 General

2.0.1 Prior Authorization and Specific Quantity Limits
Regardless of where a Prescription Order or Refill is filled, Covered Services under this Rider may be subject to drug utilization guidelines, including Prior Authorization and quantity limits, as described below.

2.0.2 Prior Authorization.
Some drugs require Prior Authorization in order for them to be Covered Services. These include but are not limited to medications that may require special medical tests before use, or that are not recommended as a first-line treatment, or that have a potential for misuse or abuse. Drugs requiring Prior Authorization are identified in the Formulary with “PA” next to the name of the drug.

Before You can fill a Prescription Order or Refill for a drug requiring Prior Authorization, the Prescribing Provider must obtain approval from Us.

2.0.3 Specific Quantity Limits. Some medications are subject to specific quantity limits. You can get information on specific quantity limits from the searchable Formulary on our web site or by contacting Our Customer Services Department. Before You can fill a Prescription Order or Refill for a drug that exceeds the specific quantity limit, the Prescribing Provider must call Us.

2.0.4 General quantity limits are addressed in the sections below.

2.0.5 Generic drugs will always be substituted when a generic Prescription Drug is available. If You or Your health care provider choose to receive a brand name Prescription Drug when a generic Prescription Drug is available, You will be responsible for the Ancillary Charge.

2.1 Participating Pharmacy

Prescription Drugs prescribed by a Prescribing Provider and obtained through a Participating Pharmacy are Covered when the Member is eligible for Coverage under this Rider and the Member presents his/her identification card to a Participating Pharmacy. Generically equivalent pharmaceuticals will be dispensed whenever there is a FDA approved generic drug.

Select oral over-the-counter medications, as determined by the Health Plan, that have been available since 2002 in an equivalent prescription dosage strength will be covered under this Rider for a Generic Copayment. Coverage of the selected oral over-the-counter medications requires a physician prescription. Over-the-counter medication Covered under this Rider will be listed on the Formulary.

Prescription Drugs will be dispensed in the quantity determined by the Prescribing Provider. The following also apply:

- One (1) Copayment is due each time a prescription is filled or refilled up to a thirty-one (31) day supply.
- Insulin and diabetic supplies (insulin syringes, with or without needles, needles, injection aids, oral agents for controlling blood sugars, glucose agents and glucagon kits, blood glucose meters, blood and urine glucose test strips, lancets and devices, ketone test strips and tabs), up to a ninety-three (93) day supply, may be dispensed with one (1) appropriate level of Copayment(s) for each prescription up to a thirty-one (31) day supply.
- Maintenance Drugs obtained through a Mail Order Pharmacy designated by the Health Plan, may be dispensed with two (2) Copayment(s) for a ninety-three (93) day supply.
- Generic oral contraceptives, up to a maximum of three (3) cycles may be dispensed with one (1) generic level Copayment(s) for each cycle.]
- Brand name oral contraceptives will be dispensed at the brand name Copayment for each cycle. The Ancillary Charge described below does not apply to brand name oral contraceptives.

However, the quantity of a Prescription Drug dispensed by a Participating Pharmacy to fill a Prescription Order or Refill should not exceed that required for the lesser of:

(a) The quantity prescribed in the Prescription Order or Prescription Refill; or
(b) a thirty-one (31) day supply; or
(c) The amount determined to be Medically Necessary by Us; or
(d) Depending on the form and packaging of the product, the following; The number of commercially prepackaged items (including but not limited to inhalers, topicals, and vials) needed for thirty-one (31) days of treatment.

The Member shall pay the Participating Pharmacy:

(a) Applicable Prescription Drug Deductibles, Copayments, Ancillary Charges, and amounts above the Annual Maximum; or
(b) One hundred percent (100%) of the cost for a Prescription Drug dispensed when the Member fails to show his/her identification card; or
(c) One hundred percent (100%) of the cost of a Prescription Drug not Covered for payment or for dispensed quantities above the approved amount.
(d) One hundred percent (100%) of the cost for a Prescription Drug if Prior Authorization is not obtained when required.
(e) The total Member cost will not exceed the Usual and Customary Charge for the prescription.

2.2 Mail Order Pharmacy

Prescription Drugs determined by Us to be Maintenance Medications on the Mail Order List and prescribed by a Prescribing Provider are Covered when obtained through the Mail Order Pharmacy and the Member is eligible for Coverage under this Rider. Generically equivalent pharmaceuticals will be dispensed by the Mail Order Pharmacy whenever there is a FDA approved generic drug. The quantity of a Prescription Drug dispensed pursuant to a Prescription Order or Refill by the Mail Order Pharmacy should not exceed that required for a ninety-three (93) day/cycle supply of approved Maintenance Medications. To access the Mail Order Pharmacy program, the Member shall mail the prescription (or refill request) to the Mail Order Pharmacy in the designated mail order prescription envelope (available through Our Customer Services Department and the Pharmacy Benefits Manager).

The Member shall pay the Mail Order Pharmacy:

(a) Applicable Prescription Drug Deductibles, Copayments, Ancillary Charges, and amounts above the Annual Maximum as specified in this Rider; or
(b) One hundred percent (100%) of the cost of a product not Covered for payment; or for dispensed quantities above the approved amount, including amounts in excess of a ninety-three (93) day supply for our approved Maintenance Medications.

(c) Members are not required to obtain Maintenance Medications from the Mail Order Pharmacy if a Pharmacy selected by the Member agrees to provide pharmaceutical services under the same terms and conditions as those provided by the Mail Order Pharmacy.

2.3 Non-Participating Pharmacy

2.3.1 Member Responsibility
Prescriptions filled at Non-Participating Pharmacies are subject to the applicable Copayment, Prescription Drug Deductible, and Prescription Drug Coinsurance amounts described in this rider. You are responsible for all pharmacy charges at the time of service. All Prior Authorization requirements, quantity limits, and other Member responsibilities described in sections 2.0 and 2.1 of this Article shall apply when You fill a prescription at a Non-Participating Pharmacy.

2.3.2 Reimbursement
The Member, upon submission of proof of payment acceptable to Us, shall be entitled to reimbursement for Prescription Drugs of no more than one hundred percent (100%) of the dollar amount paid to a Participating Pharmacy, less any applicable Prescription Drug Deductible, Prescription Drug Coinsurance, Copayments, Ancillary Charges, and amounts above the Annual Maximum. In addition, You will be responsible for the excess dollar amount between the Participating Pharmacy reimbursement amount and the cash price of the Prescription Drug. Members must submit claims for reimbursement on a claim form (available from Our agent or Us) within ninety (90) days of the date of purchase of the Prescription Drugs.

2.3.3 Reimbursement for Emergencies
Prescription Drugs prescribed for Medically Necessary Emergencies and filled by a Non-Participating Pharmacy are Covered, in full, only if a Participating Pharmacy was not available. Generically equivalent pharmaceuticals will be dispensed whenever there is a FDA approved generic drug. The Member, upon submission of proof of payment acceptable to Us, shall be entitled to reimbursement for Prescription Drugs described in this Article of no more than one hundred percent (100%) of the amount paid by the member less applicable Prescription Drug Deductibles, Prescription Drug Coinsurance, Copayments, Ancillary Charges, and amounts above the Annual Maximum. Member must submit claims for reimbursement on a claim form (available from Our agent or Us) within ninety (90) days of the date of purchase of the Prescription Drugs. Reimbursement will be limited to a quantity sufficient to treat the acute phase of the illness.

2.4 Specialty Pharmacy

2.4.1 Self-Administered Injectable Drugs are Covered under this Rider in the amounts described below when they are:
1) Ordered by a Prescribing Provider for use by a Member; and
2) Not limited or excluded elsewhere in this Rider; and
3) Obtained from a Specialty Pharmacy; and
4) Prior Authorized.

2.4.2 Filling Your Prescription Order or Refill. Self-Administered Injectable Drugs are NOT available through the Mail Order Pharmacy program or at Participating Pharmacies. You must fill Your Prescription Order or Refill for Self-Administered Injectable Drugs through the Specialty Pharmacy. If You choose to fill Your Prescription Order at a Non-Participating Pharmacy all the provisions of section 2.3 apply.

You shall pay the following to a Specialty Pharmacy, as applicable:
1) Prescription Drug Deductibles;
2) Ancillary Charges;
3) Amounts above the Annual Maximum; and
4) One (1) Self-Administered Injectable Drug Copayment per Prescription Order or Refill.

2.4.3 General Quantity Limits. In general, the quantity of a Self-Administered Injectable Drug dispensed by a Specialty Pharmacy for each Prescription Order or Refill is limited to the lesser of:
1) The amount prescribed in the Prescription Order or Refill; or
2) The amount determined by Us to be Medically Necessary; or
3) The amount determined by Us to be a thirty-one (31) day supply.

ARTICLE 3. LIMITATIONS

(a) Benefits will be paid for Covered Drugs dispensed pursuant to Prescription Order or Refill while the Member is not confined to a hospital, facility for the treatment of alcohol abuse or other Covered institution.

(b) Selected products with a narrow therapeutic index, potential for misuse and/or abuse, or a narrow or limited range of FDA approved indications may require Prior Authorization by Us and may not be available through the Mail Order Pharmacy program.
(c) Pharmacy shall not dispense a Prescription Order which, in the Pharmacist's professional judgment, should not be filled.
(d) Copayments and Ancillary Charges do not apply to the Out-of-Pocket Maximum listed on the Schedule of Benefits.
(e) Some medications are subject to quantity limits. Specific quantity limits can be obtained through Our Customer Services Department and Our searchable Formulary on Our web site.
(f) Coverage of injectable drugs is limited to Self-Administered Injectable Drugs and insulin, glucagon, bee sting kits, and Imitrex, and injectable contraceptives.
(g) Self-Administered Injectable Drugs are available only from a Specialty Pharmacy, or other Pharmacy designated by the Health Plan, unless otherwise authorized to accommodate the immediate Medically Necessary needs of the Member.
(h) Coverage of therapeutic devices or supplies requiring a Prescription Order and prescribed by a Prescribing Provider is limited to Health Plan-approved Aerochamber spacers for metered dose inhalers.
(i) Prior Authorization is required for selected products with a narrow therapeutic index, potential for misuse and/or abuse, and a narrow or limited range of FDA approved indications. These products may not be available from the Mail Order Pharmacy.
(j) Coverage through the Mail Order Pharmacy is not available for drugs that cannot be shipped by mail due to state or federal laws or regulations, or when the Health Plan considers shipment through the mail to be unsafe. Examples of these types of drugs include, but are not limited to, narcotics, amphetamines, all controlled substances, and anticoagulants.
(k) There is no coordination of benefits for outpatient Prescriptions Drugs with other health care plans, except for Medicare.

ARTICLE 4. EXCLUSIONS

The following are excluded from Coverage under this Rider:
(a) Any Prescription Drugs or injectables currently Covered in the Evidence of Coverage, regardless of this Rider;
(b) Devices or supplies of any type, even though requiring a Prescription Order, such as, but not limited to therapeutic devices, support garments, corrective appliances, non-disposable hypodermic needles, syringes (including pre-filled insulin syringes) or other devices, regardless of their intended use, unless otherwise specified as a Covered benefit in Article 2 of this Rider;
(c) Drugs prescribed and administered in the Prescribing Provider's office or during or as part of an inpatient or ambulatory surgery procedure or admission;
(d) Implantable time-released medication (e.g., Norplant, Eligard, Zoladex);
(e) Drugs which do not require a prescription by federal or state law, that is, over-the-counter drugs or over-the-counter equivalents, unless specifically designated for Coverage by the Health Plan on Our Preferred Drug List and obtained from a Participating Pharmacy with a Prescription Order or Refill;
(f) Drugs, oral or injectable, used for the primary purpose of, or in connection with treating infertility, fertilization and/or artificial insemination;
(g) Experimental Drugs or drugs prescribed for experimental (non-FDA approved/unlabeled) indications (e.g., progesterone suppositories);
(h) Drugs used for athletic performance enhancement or cosmetic purposes (e.g., anabolic steroids and minoxidil lotion, retin A (tretinoin) for aging skin);
(i) Drugs and products for smoking cessation;
(j) Vitamins and minerals (both over-the-counter and legend), except legend prenatal vitamins, and liquid or chewable legend pediatric vitamins; Coverage requires a Prescription Order from a Prescribing Provider
(k) Oral dental preparations and flouride rinses, except fluoride tablets or drops;
(l) Refill prescriptions resulting from loss or theft;
(m) Pharmacological therapy for weight reduction;
(n) Prescriptions which the Member is entitled to receive without charge under any Workers' Compensation law, occupational statute or any law, or regulation of similar purpose;
(o) Compounded hormone replacement products;
(p) Compounded prescriptions are excluded unless all of the following apply:
    (i) there is no suitable commercially-available alternative available; and
    (ii) the main active ingredient is a Covered Prescription Drug; and
    (iii) the purpose is solely to prepare a dose form that is Medically Necessary and is documented by the Prescribing Provider; and
    (iv) the claim is submitted electronically by a Participating Pharmacy.

(q) Prescriptions directly related to non-Covered services or benefits, as further described in the Evidence of Coverage;
(r) Duplicate drug therapy (i.e. two anti-histamines);
(s) Drugs, oral or injectable, used to slow or reverse normal aging processes (i.e. Growth Hormone, Testosterone) Prescription Drugs dispensed in unit doses, when bulk packaging is available, or repackaged Prescription Drugs when a charge is associated with the unit dose or repackaged item.
(t) Prescription drugs with over-the-counter equivalents or alternatives unless otherwise specified on Our Formulary; and
(u) We reserve the right to include only one (1) manufacturer's product on Our Formulary when the same drug (i.e., a drug with the same active ingredient) is made by two (2) or more different manufacturers. The product that is listed on the Formulary will be Covered at the applicable Copayment and/or Coinsurance. The product or products of the same drug not listed on the Formulary will be excluded from Coverage.

(v) We reserve the right to include only one dosage or form of a drug on our Formulary when the same drug (i.e., a drug with the same active ingredient) is available in different dosages or forms (i.e., dissolvable tablets, capsules, etc.) from the same or different manufacturers. The product, in the dosage or form that is listed in the Formulary will be Covered at the applicable Copayment and/or Coinsurance. The product or products, in different forms or dosages, not listed on the Formulary will be excluded from Coverage.

ARTICLE 5. CONDITIONS

(a) We and any of Our designees shall have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of this Rider or for appropriate medical/pharmaceutical review or quality assessment.
(b) We shall not be liable for any claim, injury, demand, or judgment based on tort or other grounds (including warranty of drugs) arising out of or in connection with the sale, compounding, dispensing, manufacturing, or use of any Prescription Drug whether or not Covered under this Rider.

ARTICLE 6. GENERAL PROVISIONS

(a) A Member's Coverage under this Rider will end when such person's Coverage under the Evidence of Coverage to which this Rider is attached ends.
(b) Nothing herein contained shall be held to vary, alter, waive, or extend any of the definitions, terms, conditions, provisions, agreements, or limitations of the Evidence of Coverage to which this rider is attached, other than as stated above.
(c) All definitions, terms, conditions, provisions, agreements, or limitations of the Evidence of Coverage to which this Rider is attached shall apply except to the extent such terms are explicitly superceded or modified by this Rider.