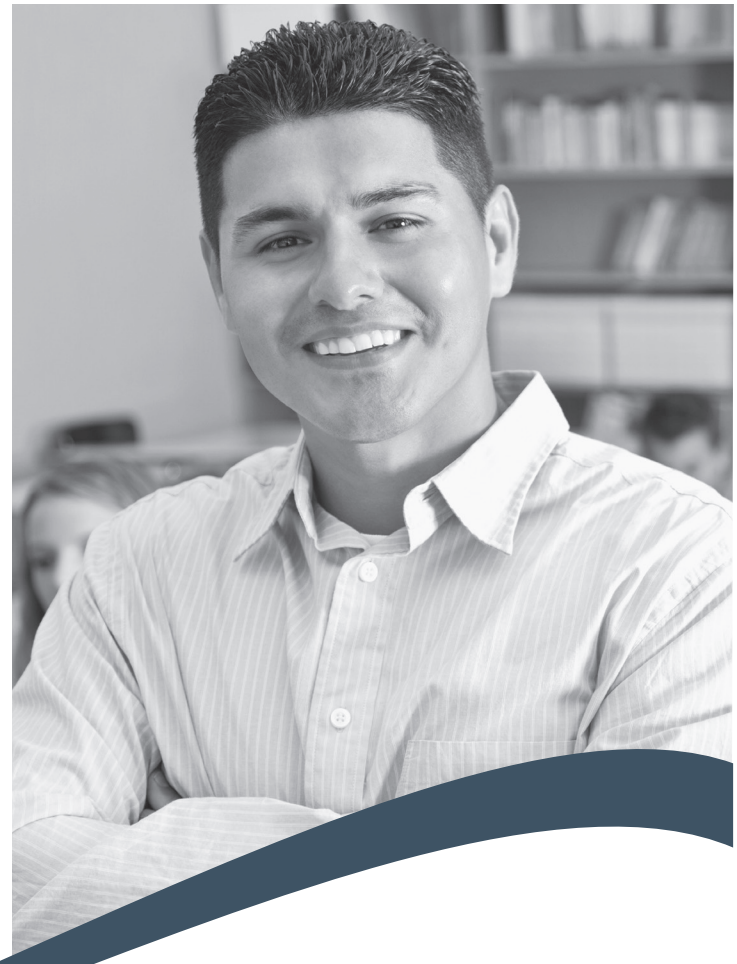
GlobalHealth

Schedule of Benefits

For Member Handbook 2016

For State, Education, and Local Government Employees



MSBST16

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Oklahoma City, OK 73104-5403
www.globalhealth.com/state

Welcome to GlobalHealth State of Oklahoma
Schedule of Benefits

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HELPFUL NUMBERS

Plan Issuer:
GlobalHealth, Inc.
PO Box 2393
Oklahoma City, OK 73101-2393
www.globalhealth.com/state

GlobalHealth Customer Care:
CommercialAnswers@globalhealth.com
405.280.5600
1.877.280.5600 (toll-free)
1.800.722.0353 or 711 (TTY/TDD/Voice)

Language Assistance – just ask for an interpreter:
405.280.5600
1.877.280.5600 (toll-free)
1.800.722.0353 or 711 (TTY/TDD/Voice)

24/7 Nurse Help Line:
Nurse Help Line
1.877.280.2993 (toll-free)

Disease Management:
CommercialAnswers@globalhealth.com
405.280.5600
1.877.280.5600 (toll-free)
1.800.722.0353 or 711 (TTY/TDD/Voice)

GlobalHealth Compliance and Privacy Line:
405.280.5852
1.877.280.5852 (toll-free)
Compliance@globalhealth.com

Behavioral & Mental Health/Chemical Dependency:
MHNet Behavioral Health
1.866.904.5234 (toll-free)
1.866.200.3269 (TTY/TDD/Voice)
www.mhnet.com

Mail Claims to:
Mental Health & Substance Abuse Claims
MHNet Claims Department
PO Box 7802
London, KY 40742

Pharmacy Benefits Manager:
Express Scripts Holding Company
1.866.274.1612 (toll-free)
1.800.899.2114 (TTY/TDD/Voice)

Medication Prior Authorizations:
918.878.7361

Mail Claims to:
Express Scripts
PO Box 66583
St. Louis, MO 63166

Mail Order Pharmacy:
Express Scripts Customer Service Center
1.866.274.1612 (toll-free)
1.800.899.2114 (TTY/TDD/Voice)
24 hours/7 days a week
www.express-scripts.com

STATE OF OKLAHOMA 2016 BENEFIT PLANS

This *Schedule of Benefits* lists Copayments and Coinsurance amounts for this specific Plan. A Copayment is a specific dollar amount associated with a benefit. Coinsurance is a percentage of the negotiated fee schedule or a percentage of the cost of a benefit if the Provider is not contracted with GlobalHealth. You will pay less out-of-pocket for some services if you choose to receive them in a Free-standing/Low-cost Facility. You may obtain these same services in a Hospital-owned Facility, but you will pay more. Be sure to ask when you make an appointment which type it is. For details of how to use this Plan, such as Network of Providers, Referrals, and Preauthorizations, see your GlobalHealth *Member Handbook*.

Benefit	You Pay
Deductible	This Plan does not have an annual Deductible.
Out-of-Pocket Maximum	Member: $3,500 per calendar year Family: $10,500 per calendar year
Primary Care Physician ("PCP") Office Visits	$0 Copayment per visit
Specialist Physician Office Visits	$50 Copayment per visit
Lab, X-ray, and Other Diagnostic Tests	$0 Copayment
#Specialized Scans, Imaging, and Diagnostic Exams	Free-standing/Low-cost Facility: $250 Copayment per scan Hospital-owned Facility: $750 Copayment per scan
Inpatient Hospital	Maternity: $500 Copayment per admission All other: $250 Copayment per day up to $750 maximum per admission
#Outpatient Surgery	Free-standing/Low-cost Facility: $250 Copayment Hospital-owned Facility: $750 Copayment
Emergency Room Services	$300 Copayment, waived if admitted to Hospital Inpatient
Urgent Care	$25 Copayment per visit
Prescription Drugs	Preferred Network Retail Pharmacy $5/$10/$50/$75$100/$200 Non-Preferred Network Retail Pharmacy $10/$15/$55/$80/$105/$205 Preferred Network Home Delivery or Extended Supply Retail Pharmacy $10/$20/$100/$150 Non-Preferred Network Home Delivery or Extended Supply Retail Pharmacy $15/$25/$105/$155

#You will pay less out-of-pocket if you choose to receive these services in a Free-standing/Low-cost Facility rather than a Hospital-owned Facility.

GlobalHealth wants to ensure that Copayments and Coinsurance are not a barrier to receiving healthcare. Providing an annual Maximum Out-of-Pocket ("MOOP") is one way GlobalHealth helps to meet this goal. A MOOP includes Copayments and Coinsurance that you pay. It does not include Premiums, healthcare your Plan doesn't cover, and Out-of-Network charges.

Per Member Maximum Out-of-Pocket: The Member does not need to pay further Copayments or Coinsurance once he/she exceeds the Per Member MOOP during the Plan year.

Family Maximum Out-of-Pocket: A Member does not need to pay further Copayments or Coinsurance once any combination of family members under the same Subscriber exceed the family annual MOOP during the Plan year.

The annual MOOP of the most current benefit Plan applies if the Member changes GlobalHealth benefit Plans during the Plan year. Copayments and Coinsurance paid under the previous GlobalHealth benefit Plan within the same Plan year will be applied to the current benefit Plan maximum. The Member is not entitled to a refund if the current annual MOOP is less than the previous maximum.

MEDICAL BENEFITS

Diabetic Supplies

Benefit Description	You Pay
• Diabetic self-management items including shoes, orthotics, needles, syringes, testing strips, and lancets	20% Coinsurance

Disease Management / Wellness Programs

Benefit Description	You Pay
• Asthma • Chronic Heart Failure • Chronic Obstructive Pulmonary Disease • Coronary Artery Disease • Diabetes • Obesity • Tobacco Cessation NOTE: See your *Member Handbook* for how to enroll in these programs.	No Copayment

Durable Medical Equipment ("DME")

Benefit Description	You Pay
• Rental or purchase, at GlobalHealth's option, including repair and adjustment • Hearing aids for children through the end of the month in which they turn age 18, 1 per ear, every 48 months, unless Medically Necessary to replace more often • For children up to age 2, four additional ear molds may be obtained per year • Must be preauthorized and obtained from a Network Provider	20% Coinsurance

Emergencies / After Hours

Benefit Description	You Pay
Ambulance • Emergency medical transportation • Non-emergency professional ambulance service when Medically Necessary and preauthorized by GlobalHealth	$100 Copayment per occurrence

Benefit Description	You Pay
(Continued) ***Emergency Room ("ER") Services*** Emergency care at a Hospital including: • Physician's services • All procedures including, but not limited to: Lab, x-rays, scans for MRI, MRA, PET, or CAT NOTE: Copayment is waived if you are admitted as an inpatient from the ER.	$300 Copayment per visit
Urgent Care Services in an Urgent Care Facility	$25 Copayment per visit

Family Planning and Maternity Care

Benefit Description	You Pay
Family Planning FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs • Contraceptive counseling • Surgically implanted contraceptives • Injectable contraceptives • Intrauterine devices • Diaphragms • Voluntary sterilization (Women only at no Cost-Share; procedures for men covered under medical/surgical benefit with applicable Copayment.)	Women: No Copayment Office Copayment may apply if in conjunction with other services. See Physician Services on page 10. Men: $50 Copayment If performed in an office setting
Infertility Services • Diagnosis and treatment of Infertility • Basic services and fertility medications NOTE: Some Infertility treatments are limited or not covered. Please refer to your *Member Handbook* for additional information.	PCP Visit: No Copayment -OR- Specialist Visit: $50 Copayment Treatment: 50% Coinsurance

Benefit Description	You Pay

(Continued)
Maternity Care
• Complete maternity care including, but not limited to:
  o Inpatient care and delivery (not subject to Preauthorization)
  o Postnatal care
• Routine newborn care (during covered portion of mother's maternity stay)
• Prenatal care and other services including, but not limited to:
  o Prenatal visits
  o Screening for gestational diabetes
  o Breastfeeding support, supplies, and counseling (Supplies limited to purchase or rental of breast pump from a Network supplier, with authorization. Includes only breastfeeding supplies contained in the breast pump kit.)
 	
NOTE: If your PCP or Specialist refers you to another Provider or Facility for additional services, you are responsible for the applicable Cost-Share.
	Inpatient for Mother and Baby:
	$500 Copayment per admission
	
	All Outpatient Postnatal Care: $25 one-time Copayment
	
	Prenatal Care and Other Services: No Copayment

Hearing and Speech Exams

Benefit Description	You Pay
• Children up to age 18 • Screening by PCP • Self-refer to Network audiologist for evaluation only	PCP Visit: No Copayment -OR- Specialist Visit: $50 Copayment

Home Healthcare

Benefit Description	You Pay
• Home Healthcare ordered by a Network physician and provided by a registered nurse (RN) or home health aide for Members who are homebound • Services provided by home health agency such as oxygen therapy, infusion therapy, and injectable medication NOTE: Limited to 100 visits per Plan year.	No Copayment

Hospice Care

Benefit Description	You Pay
• Supportive and palliative care in the home or hospice Facility for Members that have been diagnosed with a terminal illness, a life expectancy of 6 months or less, and have elected hospice care for such illness	No Copayment

Inpatient Hospital and Outpatient Surgical Care	
Benefit Description	**You Pay**
Blood and Blood Products • Processing, storage, and administration • Collection and storage of autologous blood	No Copayment
Inpatient Hospital, Facility Services • Room and board • General nursing care • Anesthesia and physician visits and services • Laboratory/Radiology/Diagnostic testing • All other Medically Necessary/authorized services • Medical supplies and equipment	Maternity: $500 per admission All other stays: $250 Copayment per day up to $750 Copayment per admission
Inpatient or Outpatient Surgery, Physician Services Surgery services of a physician in an Inpatient or Outpatient Hospital setting or an ASC including, but not limited to: • Operative procedures • Treatment of fractures including casting • Endoscopy procedures • Biopsy procedures • Circumcision • Voluntary sterilization • Treatment of burns • Anesthesia NOTE: For Facility services related to Outpatient or Inpatient surgery, please see "Inpatient Hospital, Facility Services" and "Outpatient Surgery, Facility Services".	No Copayment
Oral and Maxillofacial Surgery Limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate, or severe functional malocclusion • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures • Other surgical procedures that do not involve the teeth or their supporting structures • Orthognathic surgery when Medically Necessary (Limitations apply. See your *Member Handbook* for specific coverage and requirements.)	#Outpatient Surgery in Free-standing/Low-cost Facility: $250 Copayment -OR- Outpatient Surgery in Hospital-owned Facility: $750 Copayment -OR- Inpatient Surgery: $250 Copayment per day up to $750 Copayment per admission

Benefit Description	You Pay
(Continued) ***Organ Transplant Services*** • Outpatient • Inpatient	Office Visit: $50 Copayment Inpatient: $250 Copayment per day up to $750 Copayment per admission
Outpatient Surgery, Facility Services • Services of an Ambulatory Surgical Center ("ASC") or Outpatient Hospital related to surgical procedures • Includes all non-surgical physician services	#Free-standing/Low-cost Facility: $250 Copayment -OR- Hospital-owned Facility: $750 Copayment
Skilled Nursing Care • Subacute Care is limited to 100 days per Plan year • All care must be prescribed by a Network physician	Inpatient: $250 Copayment per day up to $750 Copayment per admission

Lab and Diagnostic Tests

Benefit Description	You Pay
Lab, X-ray, and Other Diagnostic Tests • Blood test • Non-routine Pap test • X-rays/Ultrasound • Pathology • Non-routine mammogram	No Copayment
Specialized Scans, Imaging and Diagnostic Exams Including, but not limited to: • CT scan • PET scan • SPECT scan • MRI • Nuclear scan • Sleep studies NOTE: Cost of physician interpretation included in Copayment.	#Free-standing/Low-cost Facility: $250 Copayment per scan -OR- Hospital-owned Facility: $750 Copayment per scan

Mental / Behavioral and Substance Abuse Services

Benefit Description	You Pay
Inpatient Services • Residential treatment center, limited to 100 days per Plan year • Acute Hospitalization NOTE: Self-refer for Preauthorization to MHNet. Call 1-866-904-5234.	Residential Treatment Center: $250 Copayment per day up to $750 Copayment per admission Acute Hospitalization: $250 Copayment per day up to $750 Copayment per admission
Outpatient Services • Medication management • Standard therapy sessions • Intensive Outpatient program • Partial Hospitalization (day treatment) NOTE: Self-refer for Preauthorization to MHNet. Call 1-866-904-5234.	No Copayment

Office Visits

Benefit Description	You Pay
Allergy Care • Testing and treatment • Injections NOTE: Copayment for allergy injections $30 applied once per 6-week supply of antigen and administration.	PCP Visit: No Copayment -OR- Specialist Visit: $50 Copayment
Chiropractic Care • Limited to 15 visits per Plan year	$25 Copayment per visit
Foot Care • Diabetic foot care NOTE: Routine foot care is not covered for any diagnoses other than metabolic or peripheral vascular diseases such as diabetes.	$50 Copayment per visit
Physician Services • In a physician's office • For the purpose of a second surgical opinion • In the home	PCP Visit: No Copayment -OR- Specialist Visit: $50 Copayment

Orthotics and Prosthetics

Benefit Description	You Pay
• Artificial limbs and eyes • Replacement prosthetics when device is beyond repair or patient has a physical change requiring new device • Breast prostheses and bras including replacements • Implants following mastectomy • Wigs following cancer treatment, limited to a maximum of $150 • Shoes and inserts covered for diabetics only under "Diabetic Supplies". See page 5. • Must be preauthorized and obtained from a Network Provider	20% Coinsurance

Preventive Care Services

Benefit Description	You Pay
Exam, Routine Adult • Age 19 and over • Covered once per Plan year	No Copayment Office Copayment may apply if in conjunction with other services. See Physician Services on page 10.
Exam, Routine Child • Through the end of the month in which he/she turns 19 years of age o Well-child visits o Eye screening to determine the need for Specialist Referral o Ear screening to determine the need for Specialist Referral o Oral health risk assessment	No Copayment Office Copayment may apply if in conjunction with other services. See Physician Services on page 10.
Exam, Well-Woman • Each service covered once per Plan year. Multiple visits may be required to obtain all recommended services as determined by your physician. • Services including, but not limited to: o Routine pap test o Human papillomavirus testing ("HPV") o Counseling for sexually transmitted infections o Counseling/screening for HIV o Contraceptive methods and counseling o Counseling/screening for interpersonal and domestic violence NOTE: Physical exams required for obtaining or continuing employment or insurance, for participating in sports or recreation, or for travel are not covered. See your *Member Handbook* for specific coverage.	No Copayment Office Copayment may apply if in conjunction with other services. See Physician Services on page 10.

Benefit Description	You Pay
(Continued) ***Immunization, Adult*** • Age 19 and up, when appropriate, following the recommendation of ACIP • Including, but not limited to: Hepatitis A, Hepatitis B, HPV, Flu, MMR, (Measles, Mumps, and/or Rubella), Meningococcal, Pneumococcal, TDaP (Diphtheria, Pertussis, and/or Tetanus), and Varicella NOTE: Immunizations required for work or travel are not covered.	No Copayment Office Copayment may apply if in conjunction with other services. See Physician Services on page 10.
Immunization, Child • Through the end of the month in which he/she turns 19 years of age, when appropriate, following the recommendation of the Advisory Committee for Immunization Practices ("ACIP") • Including, but not limited to: TDaP (Diphtheria, Pertussis, and/or Tetanus), Haemophilus influenza type b, Hepatitis A, Hepatitis B, HPV, Poliovirus, Flu, MMR (Measles, Mumps, and/or Rubella), Meningococcal, Pneumococcal, Rotavirus, Varicella, and any other immunization required by state law NOTE: See your *Member Handbook* for specific coverage.	No Copayment Office Copayment may apply if in conjunction with other services. See Physician Services on page 10.
Routine Mammogram • Covered for women age 35 and older • Age 35-39, one during this 5 year span • Age 40 and over, one per Plan year NOTE: See *Member Handbook* for complete list of services.	No Copayment Office Copayment may apply if in conjunction with other services. See Physician Services on page 10.
Screening, Routine Adult • Age 19 and over o Total blood cholesterol o Colorectal exam o Prostate Specific Antigen ("PSA")	No Copayment Office Copayment may apply if in conjunction with other services. See Physician Services on page 10.
Screening, Routine Child • Through the end of the month in which he/she turns 19 years of age o Developmental screening o Obesity screening and counseling	No Copayment Office Copayment may apply if in conjunction with other services. See Physician Services on page 10.

Rehabilitation Services

Benefit Description	You Pay
Cardiac and Pulmonary Rehabilitation Covered after: • Heart transplant • Bypass surgery • Myocardial infarction • Chronic Obstructive Pulmonary Disease diagnosis	$50 Copayment per visit
Physical, Occupational, and/or Speech Therapy • Limited to 60 combined rehabilitation visits per course of therapy to help Members to regain, maintain, or prevent deterioration of a skill or function that has been acquired, but then lost or impaired due to illness, injury, or disabling condition	Inpatient: No Copayment Outpatient: $50 Copayment per visit -OR- Rehabilitation Facility: $250 Copayment per day up to $750 Copayment

Temporomandibular Joint Dysfunction

Benefit Description	You Pay

Temporomandibular Joint Dysfunction
• Medically Necessary professional and Hospital Services
• Non-surgical treatment limited to a lifetime maximum of $1,500
  o Professional services, physical therapy, chiropractor, physician
  o X-rays, laboratory services
  o DME appliances, orthotic devices
• Orthognathic surgery is listed in "Oral and Maxillofacial Surgery" (Limitations apply. See your *Member Handbook* for specific coverage and requirements. Outpatient/Inpatient Copayments apply.)
	$100 Copayment per treatment plan

Treatment Therapies

Benefit Description	You Pay
• Chemotherapy • Radiation therapy • Dialysis • Respiratory/Inhalation therapy • Infusion therapy • Growth Hormone Therapy ("GHT") NOTE: Cost of treatments and medications included in Copayment.	$50 Copayment per treatment

Vision Care	
Benefit Description	**You Pay**
Exam • Self-refer to Network optometrist for one routine exam with eye refraction per year	$50 Copayment per visit
Eyeglasses • First set of basic frames and lenses following cataract surgery only • Up to a maximum of $100 reimbursement	All charges after maximum reimbursement

PRESCRIPTION DRUGS

Preferred Network Retail Pharmacy – 30-day supply	
Benefit Description	**You Pay**
Tier One • Low-cost generic drugs • Preferred generic drugs	Low-cost Generic: $5 Copayment Preferred Generic: $10 Copayment
Tier Two • Preferred brand name drugs	$50 Copayment
Tier Three • Non-preferred brand name drugs • Specified high-cost generic drugs	$75 Copayment
Tier Four • Preferred specialty drugs • Non-preferred specialty drugs	Preferred Specialty: $100 Copayment Non-preferred Specialty: $200 Copayment

Non-Preferred Network Retail Pharmacy – 30-day supply	
Benefit Description	**You Pay**
Tier One • Low-cost generic drugs • Preferred generic drugs	Low-cost Generic: $10 Copayment Preferred Generic: $15 Copayment
Tier Two • Preferred brand name drugs	$55 Copayment
Tier Three • Non-preferred brand name drugs • Specified high-cost generic drugs	$80 Copayment

Benefit Description	You Pay
(Continued) ***Tier Four*** • Preferred specialty drugs • Non-preferred specialty drugs	Preferred Specialty: $105 Copayment Non-preferred Specialty: $205 Copayment

Preferred Network Home Delivery or Extended Retail Supply Pharmacy – 90-day supply

Benefit Description	You Pay
Tier One • Low-cost generic drugs • Preferred generic drugs	Low-cost Generic: $10 Copayment Preferred Generic: $20 Copayment
Tier Two • Preferred brand name drugs	$100 Copayment
Tier Three • Non-preferred brand name drugs • Specified high-cost generic drugs	$150 Copayment

Non-Preferred Network Home Delivery or Extended Retail Supply Pharmacy – 90-day supply

Benefit Description	You Pay
Tier One • Low-cost generic drugs • Preferred generic drugs	Low-cost Generic: $15 Copayment Preferred Generic: $25 Copayment
Tier Two • Preferred brand name drugs	$105 Copayment
Tier Three • Non-preferred brand name drugs • Specified high-cost generic drugs	$155 Copayment

Contraception Prescriptions For Women

Benefit Description	You Pay
• Selected FDA-approved contraceptive prescriptions will be provided for no Copayment for women of childbearing age • All others are subject to Prescription Drug Copayments and possible prior authorization • Over the counter contraceptives are not covered unless they are FDA-approved and prescribed by a Network physician NOTE: See *Drug Formulary* for contraceptive drugs provided for no Copayment.	See Prescription Drugs (See page 12.)

Additional Information for Prescription Drugs

NOTE: Not all prescriptions are covered. Please see Limitations on page 16 and Exclusions listed on page 18 or consult GlobalHealth's Customer Care Department for additional information.

NOTE: You may purchase a 90-day extended supply from an Extended Supply Network ("ESN") pharmacy, or through Express Scripts home delivery. Your doctor must write the prescription for a 90-day supply. Some restrictions may apply. See our website for information on home delivery.

NOTE: See your *Member Handbook* for specific coverage and requirements. See your *Provider Directory* for preferred and non-preferred pharmacies. See your *Drug Formulary* for lists of drugs within each tier as well as a list of $0 Cost-Share preventive drugs.

NOTICE ON NON-DISCRIMINATION

GlobalHealth, Inc. does not discriminate on the basis of race, ethnicity, national origin, religion, gender or gender identity, sexual orientation, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), source of payment, or geographic location within the service area.

NOTICE ON BALANCE BILLING

Balance Billing occurs when a Provider bills you the difference between its billed charge and the total amount the Provider received from your Cost-Share and GlobalHealth's contracted or Usual and Customary reimbursement for approved Covered Services. In-Network Providers may not balance bill you. Out-of-Network Providers may balance bill you and you will be responsible for the difference between our payment and the Provider's billed amount.

Please note: If you choose to go to an Out-of-Network Provider, except in the case of emergency, you may be responsible for 100% of the cost.

EXCLUSIONS AND LIMITATIONS

All benefits described below are excluded or limited under this Plan.

Limitations

Ancillary Services and Supplies

- GlobalHealth will determine whether Durable Medical Equipment ("DME") items will be obtained by rental or purchase. All approved DME must be supplied by an In-Network Provider.
- Replacement, repair, or adjustments of purchased DME items are covered only when determined to be Medically Necessary.
- Rental equipment must be returned when it is no longer Medically Necessary.
- DME maintenance, only when preauthorized by GlobalHealth.
- Hearing aids are covered only for children less than eighteen (18) years of age.
- Routine corrective lenses and fittings for adults limited to first set of basic frames and lenses (up to $100.00) following cataract surgery.

- Deluxe lens features for eyeglasses such as special coating, polarization, UV treatment, etc. are not covered.
- Contact lenses are not covered.

Chiropractic Care

- Limited to fifteen (15) visits per Plan year.

Cosmetic or Plastic Surgery

- Operative procedure or any portion of a procedure performed primarily to improve physical appearance through change in bodily form. Coverage limited to:
  - Repairing conditions resulting from an accidental injury;
  - Improvement of the physiological functioning of a malformed body member not related to dentistry or dental processes to the teeth and surrounding tissue; and
  - Breast reconstruction following a Medically Necessary mastectomy.

Dental Services – Medical Coverage

- Emergency room services necessary to stabilize naturally sound teeth due to accidental injury will be covered. Replacement, re-implantation, and follow-up care of those teeth are not covered, even if the teeth are not saved by emergency stabilization.
- Orthognathic surgery is covered only when Medically Necessary (e.g., malocclusion has produced significant inability to function). Sufficient clinical documentation must be provided and services must be preauthorized.

Genetic Analysis, Services, or Testing

- Genetic counseling and testing is limited to women whose family history is associated with an increased risk for deleterious mutations in BRCA 1 and BRCA 2 genes.

Home Healthcare

- Limited to 100 visits per Plan year.

Physical Therapy and Rehabilitation Services

- Physical, occupational, and/or speech therapy services limited to sixty (60) combined visits for you to regain, maintain, or prevent deterioration of a skill or function that has been acquired, but then lost or impaired due to illness, injury, or disabling condition per course of therapy.

Prescription Drugs

- Inhaler extender devices, peak flow meters, Ana-Kits, and EpiPens are limited to three (3) per Plan year.
- Prescription diaphragms are limited to two (2) per Plan year.
- The GlobalHealth Pharmacy and Therapeutics Committee's standard quantity limits, prior authorization criteria, and step therapies apply.
- Prescription benefits cover pharmacy vaccine Network contracted immunizations that are prescribed by a Network physician and administered at a contracted vaccine Network pharmacy Provider.
- Specialty medications are limited to a one-month supply.
- Smoking cessation products are limited to two (2) full 90-day courses of any FDA-approved tobacco cessation product per plan year, if prescribed by your PCP. This benefit is available to you as well as your enrolled Dependents who are at least eighteen (18) years old. The covered medications are listed in the formulary and include: Chantix™ (varenicline),

Nicotrol® Inhaler (nicotine), Nicotrol® Nasal Spray (nicotine), and bupropion SR 150 mg (generic for Zyban®). Over-the-counter products (such as nicotine patches and gum) may be covered. See the *Drug Formulary*.
- Medications prescribed or administered by Out-of-Network physicians in non-emergencies is limited to those prescribed by dentists.

Psychiatric and Behavioral Health Services – Medical Coverage
- Autism screening is limited to children at ages eighteen (18) months and twenty-four (24) months.
- Developmental screening is limited to children up to the age of three (3) years.
- Compulsive disorders treatment is limited to programs for anorexia and bulimia when Medically Necessary.
- Other services may be covered by behavioral benefits. Call MHNet for details of coverage.

Skilled Nursing and Residential Treatment Center Care
- Limited to 100 days per Plan year.

Vision
- Limited to one (1) routine check-up, including eye refraction, per Plan year.

Exclusions

Ancillary Services and Supplies
- Routine foot care, shoes, and shoe inserts, except for Medically Necessary foot care for those persons diagnosed with diabetes or peripheral vascular disease.
- Orthopedic shoes unless permanently attached to a Denis Browne splint for children.
- Corrective shoes, arch supports, and supportive devices for the feet.
- Mattresses and other bedding or bed-wetting alarms.
- Equipment or devices not medical in nature such as braces worn for athletic or recreational use, ear plugs, elastic supports, corsets, or garter belts.
- Jacuzzi/whirlpools.
- Power-operated vehicles that may be used as wheelchairs.
- Purchase or rental of equipment or supplies for common household use including, but not limited to: Physical fitness equipment, traction tables, air conditioners, water purifiers, air-cleaning machines or filtration devices, cervical or lumbar pillows, grab bars, raised toilet seats, shower benches, beds, or chairs.
- Bandages, pads, or diapers.

Dental Services – Medical Coverage
- General dental services.
- Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and the alveolar bones).
- Correction of occlusive jaw defects, dental implants, or grafting of alveolar ridges.
- Treatment of soft tissue for the purpose of facilitating dental procedures or dentures.

Experimental or Investigational Therapies
- Medications, items, devices, and procedures that are Experimental or Investigational, except:

    - Off-label uses of certain medications used in the treatment of cancer or the study of oncology; and
    - Certain investigational uses of drugs, including chemotherapy for cancer treatment, if administered as part of an Approved Clinical Trial.
- Medications prescribed for a non-FDA approved indication, dosage, or length of therapy.
- Medications, therapies, and technologies whose long-term efficacy or effect is undetermined or unproven or whose efficacy is no greater than that of traditionally accepted standard treatment.
- New procedures, services, supplies, and medications until they are reviewed for safety, efficacy, and cost-effectiveness and approved by GlobalHealth.

Medical Care or Hospital Services

- Services that are provided without an authorization and complications arising from those services.
- Services or medications received before your start date of coverage or after the time coverage ends, even if authorized.
- Care or services provided outside the GlobalHealth Service Area if the need for such care or services could have been foreseen before leaving the Service Area.
- Services for which you do not allow the release of information to GlobalHealth.
- Services for travel, insurance, licensing, employment, school, camp, sports, premarital, or pre-adoption purposes.
- Private rooms and personal or comfort items.
- Services received while outside of the United States.
- Charges for injuries resulting from war or act of war (whether declared or undeclared) while serving in the military or an auxiliary unit attached to the military or working in an area of war whether voluntarily or as required by an employer.
- Treatment of injuries or illnesses resulting from an attempt or commission of a felony, or as a result of being engaged in an illegal occupation.
- Alopecia.
- Treatment for orthoptics or visual training for any diagnosis other than mild strabismus.
- Separate charges for missed or canceled appointments, penalty or finance charges, maintenance and/or record-keeping, record copying, or Case Management services.
- Medical care, supplies, medications, and devices for which no charge was made. Medical care, medication, and supplies for which no payment would be requested if you did not have this coverage.
- Custodial care, respite care, homemaker services, domiciliary, or convalescent care.
- Treatment of injuries or illnesses sustained or contracted as the result of being under the influence of any narcotic, unless prescribed by a physician.
- Treatment for injury resulting from extreme activities including, but not limited to:
    - Base jumping
    - Bungee jumping
    - Bull riding
    - Car racing
    - Skydiving
    - Motorcycle stunts
- Services that are not Medically Necessary.
- Medical and/or mental health treatment of any kind which is excessive or where medical necessity has not been proven.

- Alternative Medicines and/or treatments used in the place of standard therapy, to treat any condition or illness.
- Screening services requested solely by you, such as commercially advertised heart scans.

Obstetrical and Infertility Services

- Elective abortions.
- Home uterine monitoring.
- Expenses related to surrogate parenthood.
- Alternative programs for delivery such as home delivery and use of midwives and birthing centers.
- Costs resulting from a normal, full-term delivery (vaginal or caesarean section) of a baby outside of the GlobalHealth Provider Network. Full-term delivery is defined as a delivery within thirty (30) days of your due date, as specified by your GlobalHealth In-Network Provider.
- In vitro fertilization, artificial insemination, embryo transfers, reversal of voluntary sterilization, ovum transplant, gamete intrafallopian transfer ("GIFT"), zygote intrafallopian transfer ("ZIFT"), surrogate parenting, and donor semen expenses.

Other Coverage

- Treatment for disabilities connected to military service for which you are legally entitled and to which you have reasonable accessibility (i.e., services through a federal governmental agency).
- Services that are provided as a result of Workers' Compensation laws or similar laws.
- Medications for which the cost is recoverable under any other coverage, including Workers' Compensation, Occupational Disease law, or any state or government agency.

Other Exclusions

- Services resulting in whole or in part from an excluded condition, item, or service.

Physical Therapy and Rehabilitation Services

- Kinesiology, movement therapy, or biofeedback.
- Rolf technique.
- Rehabilitation treatment that will not result in measurable improvement.
- Massage therapy.
- Acupuncture/acupressure.
- Recreational therapy including, but not limited to:
  - Animal-facilitated therapy
  - Music therapy

Prescription Drugs

- Medications and dietary supplements available without a prescription (over-the-counter) or for which there is a non-prescription therapeutic equivalent available, even if ordered by a physician, unless an exception applies.
- Saline and medications for irrigation.
- Elective or voluntary enhancement procedures, services, supplies, or medications, including but not limited to: Hair growth, sexual performance, athletic performance, cosmetic purposes, and anti-aging.

- All non-prescription contraceptive jellies, ointments, foams, or devices unless they are FDA-approved and prescribed by a Network physician for a woman.
- Biological sera, medication prescribed for parenteral use or administration, allergy sera, immunizing agents, and immunizing injectable drugs with the exception of immunizations that are covered in Limitations above.
- Dietary formulas, including but not limited to total parenteral nutrition and other enteral formulas. Exception: FDA-approved low-protein formulas are covered when medically necessary for the treatment of PKU.
- Lost or stolen prescriptions.
- Prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmy, hyporgasmy, or decreased libido. (Sexual dysfunction drugs are covered only for post-prostate surgery indications and must be preauthorized by GlobalHealth.)
- Topical testosterone products (e.g., AndroGel®, Fortesta®, etc.).

Psychiatric and Behavioral Health Services - Medical Coverage

- Education, therapy, and services for the purpose of diagnosing or treating a learning disability, disruptive behavioral disorder, oppositional defiance disorder, or conduct disorder.
- Psychiatric or psychological treatment for developmental disorders, including mental retardation, pervasive developmental disorder and other specific developmental disorders, such as autism, Rett's, or Asperger's.
- Marital counseling.
- Residential treatment programs.
- Applied behavioral analysis.
- Services may be covered by behavioral benefits. Call MHNet for details of coverage.

Sex Transformation/Sexual Dysfunction

- Services related to sex transformation or sexual dysfunction of any nature, including drugs and supplies.

Transplants

- Artificial or non-human organ transplants or transplants considered experimental, investigative, or unproven.
- Transplant services rendered at a non-participating or Out-of-Network transplant Facility.
- Donor screening tests and donor search expenses.
- Lodging, meals, and transportation costs associated with organ transplantation (donor or recipient).

Transportation/Lodging

- Routine, non-emergent ambulance transport unless preauthorized by GlobalHealth.
- Lodging, meals, and transportation costs.

Vision

- Eye exercises and orthoptics.
- LASIK, INTACS, radial keratotomy, and other refractive surgery.
- Computer programs of any type, including, but not limited to, those to assist with vision therapy.
- Special multifocal ocular implant lenses.

Weight Reduction Programs

- Gastric stapling, gastric balloon services, or any surgical treatment for obesity or weight-loss purposes.

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