Bluegrass Family Health

2012 Kentucky Certificate of Coverage

Bluegrass Family Health

651 Perimeter Drive, Suite 300
Lexington, KY 40517

Health Maintenance Organization

HOW TO USE THIS CERTIFICATE

READ YOUR CERTIFICATE CAREFULLY. This Cover Sheet provides only a brief outline of some of the important features of Your health care coverage.

This Evidence of Coverage ("Certificate") explains Your health care coverage under the terms and conditions of the Group Contract issued to Your Employer Group by Us, and based upon the benefit plan Your Employer Group has selected for You. This Certificate overrides and replaces any Certificate of Coverage previously issued to You. The Group Contract, including this Certificate, any Addendums, Amendments, Riders, Schedules, Rate Sheets and Endorsements attached to it, and the Application for coverage signed by the Employer Group (including individual employee applications), constitutes the entire Group Contract and legal document under which the Covered Services described herein are being made available to You. No change in this Certificate shall be valid until approved by an executive officer of Bluegrass Family Health (BFH) and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Certificate or to waive any of its provisions.

IT IS IMPORTANT THAT YOU READ YOUR CERTIFICATE CAREFULLY. This Certificate describes Your rights and responsibilities as a Member. Certain services are not covered by the Plan and other Covered Services are limited. The Plan will not pay for any service not specifically listed as a Covered Service, even if a Participating Provider recommends or orders that Non-Covered Service.

A TABLE OF CONTENTS FOLLOWS, SHOWING YOU WHERE TO LOOK FOR INFORMATION CONCERNING SPECIFIC AREAS.

Once again, We urge You to READ YOUR CERTIFICATE CAREFULLY. This Certificate should be read in its entirety. Since many of the provisions of this Certificate are interrelated, You should read the entire Certificate to get a full understanding of Your coverage.

If You have any questions regarding this Certificate, You may contact the Customer Service Department at Bluegrass Family Health (BFH) by using Our toll free telephone number (800) 787-2680 or by accessing Our website at www.bgfh.com.

BFH, in accordance with federal and state law, does not discriminate in the employment of staff or in the provisions and quality of access to healthcare services delivered to Members on the basis of race, sex, sexual orientation, age, religion, place of residence, health status, ethnicity, creed, national origin, or source of payment.

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MEMBER RIGHTS & RESPONSIBILITIES

As Our Member, You have the Right to:

- Receive information about BFH, Our services and Our Providers;
- Receive quality health care through Your Providers in a timely manner and in a medically appropriate setting;
- Receive complete information from Your Provider regarding Your diagnosis, treatment and prognosis in a manner You can understand.
- Be treated with respect and recognition of Your dignity and right to privacy;
- Receive benefits to which You are entitled under Your Certificate;
- Participate with practitioners in decision-making regarding Your health care;
- Have a candid discussion of appropriate or Medically Necessary treatment options for Your condition, regardless of cost or benefit coverage;
- Refuse treatment and be informed by Your Providers of the medical consequences;
- Express to Us concerns and complaints about the care or services provided by Physicians and other Providers, and to have Us investigate and take appropriate action; and
- Voice complaints or appeals about BFH or the care provided.
- You have the right to a copy of Your Certificate.
- You have the right to telephone access to BFH during business hours to ensure access for routine care.
- You have the right to twenty-four (24) hour telephone access to either a BFH Representative or a Participating Provider.
- You have the right to receive Emergency services (and coverage of care obtained in an Emergency).

As Our Member, You have the Responsibility to:

- Provide, to the extent possible, accurate and complete information to Us and to Your Providers;
- Understand how to access care in Emergency, Urgent and routine situations;
- Know how Your health care benefits work, including out of Service Area coverage, Deductibles, Coinsurance, Copayments, coverage Exclusions, etc.;
- Follow the plans and instructions for care that You have agreed on with Your practitioners;
- Treat Your Providers, other Members and Our staff in a courteous and respectful manner; and
- Read and understand Your Certificate.

NOTICE OF PRIVACY PRACTICES AVAILABILITY

In compliance with federal requirements, Bluegrass Family Health (BFH) shall make available to all members a Notice of Privacy Practices. A copy of the Notice of Privacy Practices is included in Your Certificate of Coverage. You may also obtain a Notice of Privacy Practices on Our website at www.bgfh.com, or by contacting Us at:

Bluegrass Family Health
Attn: Privacy Officer
651 Perimeter Drive, #300
Lexington, Kentucky 40517
(859) 269-4475
(800) 787-2680
(859) 335-3720 fax
Privacy.Officer@bgfh.com

NOTICE OF PRIVACY PRACTICES

Effective April 14, 2006

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

At BFH, We respect the confidentiality of Your Protected Health Information (PHI) - health information about You that can identify You and will protect such information in a responsible and professional manner. We are required by law to maintain the privacy of Your health information and to abide by the terms of this Privacy Notice.

This Notice explains how We use PHI and when We can share that information with others. It also informs You of Your rights with respect to Your PHI and how You can exercise those rights.

OUR LEGAL DUTIES

BFH is required by law to protect Your PHI and to give You notice of Our legal duties and privacy practices concerning Your PHI.

- BFH must abide by the terms of this Notice;
- BFH must notify You if We are unable to agree to a restriction that You request about the use and disclosure of Your PHI;
- BFH must accommodate reasonable requests You may have to communicate health information by alternative means or at alternative locations.
- BFH will not use or disclose Your health information without Your authorization, except as described in this Notice.

HOW WE USE OR SHARE PROTECTED HEALTH INFORMATION

We will use or disclose Your PHI for treatment, to obtain payment for treatment, and for health care operations. Listed below are some examples of how We can use or share Your PHI. The examples given are not meant to be exhaustive, but describe common types of disclosures BFH may make.

Examples of Uses and Disclosures for Treatment: **[164.520 (b)(1)(ii)(A)]**

A. We may share Your PHI with Your doctors, hospitals or other medical Providers to help them provide medical care to You. For example, if You are in the hospital, We may give them access to any medical records sent to Us by Your doctor.

B. We may use or share Your PHI with others to help manage Your health care. For example, We might talk to Your doctor to suggest a disease management or wellness program that could help improve Your health.

Examples of Uses and Disclosures for Payment:

A. We may use Your PHI to determine eligibility and process Your claims.

B. We may share Your PHI with another covered entity to determine who is primary on Your claims.

Examples of Uses and Disclosures for Health Care Operations:

A. We may share Your PHI with entities that We have delegated services to, such as but not limited to, Our pharmacy benefits manager. We will not share Your PHI with any delegated entity unless they agree to keep it protected.

B. We may use or share Your PHI to give You information about alternative medical treatments and programs or about health related products and services that You may be interested in. For example, We might send You information about smoking cessation or weight loss programs.

OTHER USES OR DISCLOSURES THAT MAY BE MADE WITHOUT YOUR AUTHORIZATION

BFH may use or disclose Your health information without Your authorization for the following reasons:

Business Associates of BFH: Some services are provided through contracts with business associates. Examples include pharmacy benefits management and claims processing services. When these services are contracted, BFH may disclose Your health information to BFH business associates so that they can perform the job BFH has asked them to do and bill You or Your insurance carrier for services rendered. To protect Your health information, however, BFH requires the business associate to appropriately safeguard Your information.

Research: BFH may disclose limited information for medical research under certain circumstances.

Marketing: BFH may use or disclose health information to contact You with information about treatment, services, products or health care Providers that may be of interest to You.

Funeral Directors, Coroners and Medical Examiners: BFH may disclose health information to a coroner, medical examiner or funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, BFH may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Food and Drug Administration (FDA): BFH may disclose health information to the FDA relative to adverse events with respect to food, supplements, product and product

defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Public Health: As required by law, BFH may disclose Your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability. These include activities such as reporting births, deaths, disease, injury, child abuse or neglect and domestic violence.

Inmates: If You are an inmate of a correctional institution, or under the custody of a law enforcement official, BFH may disclose Your health information to the institution or law enforcement official as may be necessary for Your health and the health and safety of other individuals.

Legal Proceedings: If You are involved in a lawsuit or dispute, BFH may disclose Your health information in response to a court or administrative order. BFH also may disclose Your health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell You about the request or to obtain an order protecting the information requested.

Law Enforcement: BFH may disclose health information for law enforcement purposes as required by law or in response to a valid court order, subpoena, warrant, summons or similar process. This includes providing information about someone who is suspected to be a victim of a crime, abuse, neglect or domestic violence; to provide information about a crime that occurs at BFH or to identify or locate a suspect, fugitive, material witness or missing person.

Health Oversight Activities: BFH may disclose Your health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights.

Military Activity and National Security: BFH may release Your health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law, including providing protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

USES AND DISCLOSURES THAT REQUIRE YOUR WRITTEN AUTHORIZATION

BFH will not disclose PHI as it relates to mental health and chemical dependency unless permitted or required by applicable law.

For any other disclosures that are not provided for by state and/or federal law, We must get Your written permission (authorization) to use or share Your protected health information (PHI). If You give Us written permission (authorization) and You later change Your mind, You may revoke Your written permission at any time.

WHAT ARE YOUR RIGHTS?

A. **You have the right to inspect and copy PHI** that is maintained in Our designated record set or that of any of Our business associates. However, You do not have the right to access certain types of information, and We may decide not to provide You with copies of:
   1. psychotherapy notes;

2. information compiled in reasonable anticipation of, or for use in a civil, criminal or administrative action or proceeding; and
3. information subject to certain federal laws governing biological products and clinical laboratories.

B. **You have the right to ask Us to restrict** how We use or disclose Your information for treatment, payment, or health care operations. You also have the right to ask Us to restrict information that We have been asked to give to family members or to others who are involved in Your health care or payment for Your health care. Please note that while We will try to honor Your request, We are not required to agree to these restrictions.

C. **You have the right to ask to receive confidential communications** of information. For example, if You believe that You would be harmed if We send Your information to Your current mailing address (in situations involving domestic disputes or violence); You can ask Us to send the information by alternative means, such as fax, or to an alternative address. We will accommodate Your reasonable requests as explained above.

D. **You have a right to receive a copy of this Notice upon request at any time.** You can also view a copy of the Notice on Our website at www.bgfh.com.

E. **You have a right to amend** Your PHI if it is inaccurate or incomplete. In certain other situations, We may deny Your request to inspect or obtain a copy of Your information. If We deny Your request, We will notify You in writing and may provide You with a right to have the denial reviewed.

F. **You have the right to receive an accounting** of how We have disclosed Your PHI. Please note that We are not required to provide You with an accounting of the following information:
   1. Any information collected prior to April 14, 2003;
   2. Information disclosed to You or pursuant to Your authorization;
   3. Information used or shared for treatment, payment and health care operations;
   4. Information that is incidental to a use or disclosure otherwise permitted;
   5. Information disclosed for a facility's directory or to persons involved in Your care or other notification purposes;
   6. Information disclosed for national security or intelligence purposes;
   7. Information disclosed to correctional institutions, law enforcement officials or health oversight agencies;
   8. Information disclosed or used as part of a limited data set for research, public health, or health care operations purposes.

We may require that Your request be in writing. We will act on Your request for an accounting within 60 days. We may need additional time to act on Your request. If so, We may take up to an additional 30 days. Your first accounting request will be free. We will continue to provide You with one free accounting upon request every 12 months. If You request an additional accounting within 12 months of receiving Your free accounting, We may charge You a fee. We will inform You in advance of the fee and provide You with an opportunity to withdraw or modify Your request.

Should any of Our privacy practices change, We reserve the right to change the terms of this Notice and to make the new Notice effective for all PHI We maintain. Once

revised, We will provide the new Notice to You by direct mail and post it on Our website.

Please contact Our Privacy Officer if You have any questions about this Notice or about how We use or share PHI, or if You believe Your privacy rights have been violated.

Bluegrass Family Health
Attn: Privacy Officer
651 Perimeter Drive, #300
Lexington, Kentucky 40517
(859) 269-4475
(800) 787-2680
(859) 335-3720 fax
Privacy.Officer@bgfh.com

You may also notify the Secretary of the U.S. Department of Health and Human Services of Your complaint at 200 Independence Avenue, S.W., Washington, D.C. 20201, or telephone at (202) 619-0257 or (877) 696-6775.

DEFINITIONS

This section defines words and phrases having special meanings. If a word or phrase starts with a capital letter, it has a special meaning. It is defined in the Definitions section or where used in the text.

ACCIDENTAL INJURY (OR ACCIDENTALLY INJURED)
A sudden or unforeseen result of an external agent or trauma, independent of illness, which causes injury, including complications arising from that injury, to the body, and which is definite as to time and place.

ACTIVELY AT WORK
Present and capable of carrying out the normal assigned job duties of the Group. Subscribers who are absent from work due to a health related disability, maternity leave or regularly scheduled vacation will be considered Actively At Work.

ADVERSE DETERMINATION
A denial or reduction of benefit(s) or services based upon Medical Necessity (not Medically Necessary), Experimental, or Investigational purposes, or similar exclusion or limit.

AMBULANCE
A certified vehicle for transporting ill or Accidentally Injured people that contains all life saving equipment and staff as required by state and local laws.

AMBULATORY SURGICAL CENTER/AMBULATORY SURGICAL FACILITY
A Provider with an organized staff of Physicians which:

A. has permanent facilities and equipment for the primary purpose of performing surgical and/or medical procedures to an Outpatient;
B. provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility; and
C. does not provide accommodations to Inpatients.

AUTHORIZED PERSON OR REPRESENTATIVE
A spouse, parent, guardian or other person, authorized to act on behalf of a Member with respect to health care decisions.

AUTISM
A. Autism Spectrum Disorders
A physical, mental, or cognitive illness or disorder which includes any of the pervasive development disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association, including Autistic Disorder, Asperger's Disorder, and Pervasive Development Disorder Not Otherwise Specified.

B. Applied Behavior Analysis (ABA)
The design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement

in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

C. Habilitative or rehabilitative care (as it relates to Autism Spectrum Disorders) Professional counseling and guidance services, therapy, and treatment programs, including ABA that are necessary to develop, maintain, and restore, to the minimum extent practicable, the functioning of an individual.

CALENDAR YEAR
A twelve (12) month period beginning January 1 and ending December 31. For new Enrollees, the Calendar Year begins on the Effective Date of their enrollment and ends on December 31 of the same year.

CALENDAR YEAR DEDUCTIBLE
A Deductible amount that applies to all eligible medical and pharmacy expenses with a date of service during one Calendar Year, beginning January 1 and ending December 31.

CERTIFICATE OF COVERAGE (CERTIFICATE, COC)
This Evidence of Coverage document, which includes: Member Rights & Responsibilities, Notice of Privacy Practices, Schedules of Benefits, Definitions, Eligibility & Enrollment, Termination of Coverage, Plan Delivery System Rules, Benefits, Exclusions, General Provisions and Member Inquiry, Complaint, Grievance & Appeals Procedures. This Certificate is part of and incorporated in the Group Contract by reference, and coverage under this Certificate is coverage under the Group Contract.

COINSURANCE
The percentage of an Eligible Expense that must be paid by the Covered Person for certain Covered Services. Coinsurance does not include Deductibles, Copayments, or non-covered expenses during the Plan Year.

CONTRACT
This agreement, any Supplemental Benefit Riders, the Premium Schedule and the application signed by the Employer.

COPAYMENT
A specified amount the Covered Person must pay at the time services are rendered for certain Covered Services, which may not be used as part of the Deductible.

COVERED PERSON
The Member and Dependents covered under this Certificate.

COVERED SERVICE
A service or supply that is available under the Plan, when Medically Necessary or otherwise specifically included as a benefit under this Certificate, within the scope of the license of the Provider performing the service, rendered while coverage under this Certificate is in force, is not Experimental/Investigational or otherwise excluded or limited by this Certificate, or by any amendment or rider thereto, authorized in advance by Us if such Prior Authorization (PA) is required in this Certificate, and is obtained in full compliance with all Plan Delivery System Rules.

Please refer to the Plan's Delivery System Rules. A charge for a Covered Service shall be considered to have been incurred on the date the service or supply was provided.

CREDITABLE COVERAGE

Prior coverage from a group plan, Medicare (Part A or Part B of Title XVIII of the Social Security Act), Medicaid (Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928), health plan for active military personnel, including TRICARE (Chapter 55 of Title 10, United States Code), Indian Health Service or of a tribal organization, state health benefits risk pool, Federal Employees Health Benefits Program (Chapter 89 of Title 5, United States Code), public health plan established or maintained by a State, the United States, a foreign country, or any political subdivision thereof, individual insurance policy, Peace Corps service or Title XXI of the Social Security Act such as State Children's Health Insurance Program or any other similar coverage permitted under state or federal law or regulations. Prior coverage does not count as Creditable Coverage if there was a break of sixty-three (63) days or more prior to applying for this coverage.

Creditable Coverage does not include coverage consisting solely of coverage of Excepted Benefits. "Excepted Benefits" means benefits or coverage under one or more (or any combination thereof) of the following:

A. Coverage only for accident (including accidental death and dismemberment);
B. Disability income insurance;
C. Liability insurance, including general liability insurance and automobile liability insurance;
D. Coverage issued as a supplement to liability insurance;
E. Workers' Compensation or similar insurance;
F. Automobile medical payment insurance;
G. Credit-only insurance (for example, mortgage insurance);
H. Coverage for on-site medical clinics;
I. Other similar insurance coverage, under which benefits for medical care are secondary or incidental to other insurance benefits; or
J. The following benefits if offered separately from medical expense benefits (provided under a separate policy, certificate, or contract of insurance, or otherwise not an integral part of the plan);
    1. Limited scope dental or vision benefits;
    2. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof;
    3. Other similar limited benefits.

The following benefits if offered as independent, noncoordinated benefits:

A. Coverage only for a specified disease or illness; or
B. Hospital indemnity or other fixed indemnity insurance.

The following benefits if offered as a separate insurance policy:

A. Medicare supplement insurance;
B. Coverage supplemental to Tricare; or
C. Similar supplemental coverage provided to coverage under a group health plan.

Health flexible spending arrangement, if the following are satisfied:
A. The maximum benefit from employee and employer contributions for the year does not exceed two times the employee's annual salary reduction; and
B. The employee has other group health coverage available that is not limited to excepted benefits.

CUSTODIAL CARE
Care provided primarily for maintenance of the patient or which is designed essentially to assist the patient in meeting activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an illness, disease, Accidental Injury, or condition. Examples of Custodial Care include help in walking, bathing, dressing, feeding, preparation of special diets, catheter care, feeding by utensil, tube or gastrostomy, transfer or positioning in bed, and supervision over self-administration of medications not requiring constant attention of trained medical personnel.

DEDUCTIBLE
A specified dollar amount of Covered Services that must be incurred by You, either individually or combined as a covered family, before any benefits are payable by Us for all or part of the remaining Plan Year.

DEPENDENT
A person of the Subscriber's family who is eligible for coverage under the Certificate as described in the Eligibility & Enrollment section.

DIAGNOSTIC SERVICE
A test or procedure rendered because of specific symptoms and which is directed toward the diagnosis or monitoring of a certain condition or disease. A Diagnostic Service also includes a test performed as a Medically Necessary Preventive Care screening for an asymptomatic patient. A Diagnostic Service must be ordered and performed by a Physician or other health care Provider. Covered Diagnostic Services are limited to those services specifically listed in the benefits section.

DURABLE MEDICAL EQUIPMENT
Equipment the Plan determines to be:
A. Ordered or provided by a Physician for outpatient use;
B. Designed and able to withstand repeated use;
C. Used primarily for medical purposes;
D. Medically Necessary and necessitated by Your injury or sickness;
E. Not of use to a person in the absence of a disease or disability; and
F. Suitable for use in the home.

EFFECTIVE DATE
The date on which coverage for a Covered Person begins. You must be Actively At Work on Your Effective Date. If You are not Actively At Work on Your Effective Date, Your Effective Date will be the date You become Actively At Work. A Dependent's coverage begins on the Effective Date of the sponsoring Subscriber.

ELECTIVE PROCEDURE
A medical procedure which is not considered to be urgent or emergent by nature or one which may be delayed by the Covered Person to a later point in time.

ELIGIBLE EXPENSE
The lesser of the Provider's usual charge for a given service, which is within the range of fees charged by Providers of similar training and experience for the same or similar service or supply within the same or similar limited geographical area or the fee schedule developed by the Plan.

EMERGENCY MEDICAL CONDITION
A medical condition or accidental traumatic bodily injury manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent lay person would reasonably have cause to believe constitutes a condition that the absence of immediate medical attention could reasonably be expected to result in:

A. Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy;
B. Serious impairment to bodily functions; or
C. Serious dysfunction of any bodily organ or part.

With respect to a pregnant woman who is having contractions:

A. A situation in which there is inadequate time to effect a safe transfer to another Hospital before delivery; or
B. A situation in which transfer may pose a threat to the health or safety of the woman or the unborn child.

EMERGENCY CARE
Covered Services that are furnished by a Provider within the scope of their license and as otherwise authorized by law that are needed to evaluate or Stabilize an individual in an Emergency.

ENROLLMENT DATE
The first day of coverage of a Member under this Certificate, or if there is a Waiting Period, the first day of the Waiting Period (typically the date employment begins).

EXPERIMENTAL OR INVESTIGATIONAL SERVICES
Services or supplies, including treatments, procedures, hospitalizations, drugs, equipment, diagnostic, biological products or medical devices, used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which We determine in Our sole discretion to be Experimental or Investigational, or a Peer Review Panel determines are:

A. not of proven benefit for the particular diagnosis or treatment of the Covered Person's particular condition;
B. not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of the Covered Person's particular condition; or
C. provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

The Plan will not deny coverage solely on the fact that the Covered Person is/was a participant in a clinical trial program. The Plan will not cover any services or

supplies, including treatment, procedures, drugs, biological products or medical devices or any hospitalization in connection with Experimental or Investigational services or supplies. The Plan shall not cover any technology or any hospitalization in connection with such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of the Covered Person's particular condition. Government approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of the particular condition as explained below.

The Plan shall apply the following five criteria in determining whether services or supplies are Experimental or Investigational:

A. Any medical device, drug, or biological product must have received final approval to market by the United States Food and Drug Administration (FDA) for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug, or biological product for another diagnosis or condition shall require that one or more of the following established reference compendia: The American Medical Association Drug Evaluations; The American Hospital Formulary Service Drug Information; or The United States Pharmacopoeia Drug Information recognize the usage as appropriate medical treatment. As an alternative to such recognition in one or more of the compendia, the usage of the drug shall be recognized as appropriate if it is recommended by a clinical study and recommended by a review article in a major peer reviewed professional journal. A medical device, drug, or biological product that meets the above tests shall not be considered Experimental or Investigational. In any event, any drug that the FDA has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental or Investigational.

B. Conclusive evidence from the published peer-review medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results, supported by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale.

C. Demonstrated evidence as reflected in the published peer-review medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects.

D. Proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and

E. Proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph C, are possible in standard conditions of medical practice, outside clinical investigatory settings.

FAMILY COVERAGE
Coverage for the Subscriber and eligible covered Dependents.

FAMILY MAXIMUM DEDUCTIBLE
The total sum of Eligible Expenses applied toward the Deductible for persons covered under the Member's Certificate.

GRANDFATHERED GROUP HEALTH BENEFIT PLAN
A group health plan in which individuals were enrolled on March 23, 2010.

GROUP CONTRACT
The Group Contract between BFH and the Employer Group and any addenda, endorsements or schedules incorporated therein, this Certificate, and any amendments, schedules, supplemental benefit riders or endorsements attached to it, the Employer Group application; the individual applications and any reclassifications thereof submitted by Eligible Persons and BFH's applicable Underwriting Guidelines.

HEARING AID AND RELATED SERVICES
Any wearable, non-disposable instrument or device designed to aid or compensate for impaired human hearing and any parts, attachments, or accessories, including ear molds and those services necessary to assess, select, and appropriately adjust or fit the hearing aid to ensure optimal performance, excluding batteries and cords.

HOME HEALTH AGENCY
An agency that provides intermittent skilled nursing and health related services to patients in their home under a plan prescribed by a Physician. The agency must be licensed as a Home Health Agency by the state in which it operates, or be certified to participate in Medicare as a Home Health Agency.

HOSPICE
A Provider, other than a facility that treats Inpatients, which is primarily engaged in providing pain relief, symptom management, and supportive services to terminally ill persons and their families. The facility must be operated in accordance with the laws of the jurisdiction in which it is located.

HOSPITAL
An acute care licensed institution engaged in providing medical care and treatment to a patient for a charge as a result of illness, accident, or mental disorder on an inpatient or outpatient basis at the patient's expense and which fully meets all the tests set forth in A, B, and C below:

A. It is a hospital accredited by the Joint Commission on the Accreditation of Healthcare Organizations, the American Osteopathic Association, or the Commission on the Accreditation of Rehabilitative Facilities, or certified by the Kentucky Division of Licensure and Regulation;
B. It maintains diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of patients under the supervision of a staff of fully licensed Physicians. However, no claim for payment of treatment, care, or services shall be denied because a hospital lacks major surgical facilities and is primarily of a rehabilitative nature, if such rehabilitation is specifically for treatment of physical disability; and

C. It continuously provides twenty-four (24) hours a day nursing service by or under the supervision of registered graduate nurses.

INPATIENT
A Covered Person who is treated as a registered bed patient in a Hospital or other institutional Provider and for whom a room and board charge is made.

LARGE EMPLOYER
This definition only applies to Large Employer Groups.
An employer with fifty-one (51) or more employees; or an affiliated group of fifty-one (51) or more eligible members.

LATE ENROLLEE
An individual whose enrollment under the Plan is a Late Enrollment.

LATE ENROLLMENT
Enrollment other than during the initial thirty-one (31) day enrollment period, or during a Special Enrollment Period.

LIFETIME MAXIMUM
The maximum dollar amount the Plan will pay for Covered Services during Your lifetime.

MEDICALLY NECESSARY (OR MEDICAL NECESSITY)
The services or supplies furnished by a Provider that are required to identify or treat a Covered Person's illness or injury and which, as determined by the Plan, are:

A. Consistent with the symptom or diagnosis and treatment of the Covered Person's condition, disease, ailment, or injury;
B. Appropriate with regard to standards of good medical practice;
C. Not solely for the convenience of a Covered Person or Provider; and
D. The most appropriate supply or level of service that can be safely provided to the Covered Person. When applied to the care of an Inpatient, it further means that the Covered Person's medical symptoms or condition require that the services cannot be safely provided as an Outpatient.

MEMBER
An individual eligible for coverage with a Group who meets all eligibility requirements. The term "Member" includes any such individual whether referred to as "Member," "Enrollee," "Insured," "Subscriber," "Participant," "You," "Your" or otherwise.

MENTAL HEALTH CONDITION
A condition that manifests symptoms that are primarily mental or nervous, regardless of any underlying physical cause. Examples of Mental Health Conditions include psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

In determining whether or not a particular condition is a Mental Health Condition, the Plan may refer to the current edition of the Diagnostic and Statistical Manual of

Mental Conditions of the American Psychiatric Association, or the International Classification of Diseases (ICD) manual.

NON-PARTICIPATING PROVIDER
Any Provider other than a Participating Provider.

NUTRITIONAL COUNSELING
An individualized program of nutritional evaluation, counseling, and dietary recommendations provided by physicians, mid-level Providers, or registered dieticians or nutritionists. Nutritional Counseling may be Medically Necessary as part of the overall treatment plan to treat individuals with medical conditions that have been shown to have better health outcomes through healthy eating habits and dietary modification, such as diabetes mellitus or chronic renal failure.

OBSERVATION
Service of a patient that does not require the constant availability of medical supervision or Skilled Nursing Care to monitor a condition. The primary purpose of such service is to arrive at a diagnosis through the use of x-ray and laboratory tests, consultations and evaluation, as documented by the Hospital's medical records. The timeframe for observation is generally twelve (12) to twenty-four (24) hours.

OUT-OF-POCKET LIMIT
The maximum amount of Deductible and Coinsurance You pay every Plan Year. When the Out-of-Pocket Limit is reached, Coinsurance ceases for the rest of the Plan Year.

Any amounts not paid because a maximum benefit limit has been reached, any charges for Non-Covered Health Services, Copayments and/or Coinsurance for Covered Health Services available by an optional rider, any Copayments and/or Coinsurance for prescription drugs (if prescription drugs are a covered benefit in Your plan), infertility Copayments and/or Coinsurance (if infertility is a covered benefit in Your plan), Copayments or any amount above an Eligible Expense will never apply to the Out-of-Pocket Limit. The particular Out-of-Pocket Limit for Your plan is identified on Your Schedule of Benefits.

Even when the Out-of-Pocket Limit has been reached, You will still be required to pay any charges for non-Covered Services, Copayments and/or Coinsurance for Covered Health Services available by an optional rider, any Copayments and/or Coinsurance for prescription drugs (if prescription drugs are a covered benefit in Your plan), infertility Copayments and/or Coinsurance (if infertility is a covered benefit in Your plan), Copayments and any amount above an Eligible Expense.

OUTPATIENT
A Covered Person who receives services or supplies while not an Inpatient.

PARTICIPATING PROVIDER
Any Provider who has an agreement with the Plan or the Plan's associated medical groups to provide Covered Services.

PHYSICIAN
Any Doctor of Medicine or Doctor of Osteopathy who is licensed and legally entitled to practice medicine, perform surgery, and dispense drugs.

PHYSICIAN ASSISTANT
A person who has graduated from a physician assistant or surgeon assistant program accredited by the Accreditation Review Commission on Education for Physician Assistants or its predecessor or successor agencies and has passed the certifying examination administered by the National Commission on Certification of Physician Assistants or its predecessor or successor agencies, or possesses a current physician assistant certificate issued by the board prior to July 15, 2002.

PLAN
Bluegrass Family Health, sometimes referred to "We," "Us," or "Our."

PLAN DELIVERY SYSTEM RULES
A section of this Certificate that describes the Plan's specific procedures that must be followed to obtain maximum benefits for Covered Services.

PLAN YEAR
Please consult Your Schedule of Benefits or contact Customer Service for Your specific Plan or Calendar Year.

PREMIUM
The periodic charges due which the Covered Person or the Covered Person's group must pay to maintain coverage.

PREMIUM DUE DATE
The date on which a Premium is due under this Certificate.

PRE-EXISTING CONDITION
A mental or physical condition, which was present and for which medical advice, diagnosis, care or treatment was taken into account only if it is recommended by, or received from, an individual licensed or similarly authorized to provide such services under state law and operating within the scope of practice authorized by state law; and the six (6) month period ending on the Enrollment Date begins on the six (6) month anniversary date preceding the Enrollment Date. The Exclusion Period for coverage of a Pre-Existing Condition does not apply to the following: Enrollees under the age of nineteen (19), pregnancy, genetic information in the absence of a diagnosis, or a claim resulting from domestic violence.

PREVENTIVE SERVICES
Services determined to be effective and accepted for the prevention of disease in persons with no symptoms.

PRIMARY CARE PHYSICIAN
A Participating Provider who is a practitioner specializing in family practice, general practice, internal medicine, obstetrics/gynecology (for OB/GYN services only), or pediatrics who supervises, coordinates and provides initial care and basic medical services to a Covered Person.

PRIMARY RESIDENCE
The location where the Member resides for a majority of the Plan Year, with the intention of making the Member's home, and not for a temporary purpose. Temporary absences with the intent to return, will not interrupt the Covered Person's Primary Residence.

PRIOR AUTHORIZATION (PA)
Authorization by the Plan that is required before services are performed or dispensed.

PROVIDER
A facility or person, including a Hospital or Physician and including a Doctor of Osteopathy, which is licensed where required to render Covered Services. Providers other than a Hospital or Physician, including a Doctor of Osteopathy, include:

- Advanced Practice Registered Nurse
- Ambulatory Care Facility
- Licensed Audiologist
- Birthing Center
- Certified Psychologist
- Certified Surgical Assistant
- Doctor of Chiropractic
- Doctor of Dental Medicine
- Doctor of Dental Surgery
- Doctor of Optometry
- Doctor of Podiatry
- Freestanding Renal Dialysis Facility
- Home Health Agency
- Hospice
- Licensed Clinical Social Worker
- Licensed Marriage and Family Therapist
- Licensed or Certified Nurse Midwife
- Licensed Occupational Therapist
- Licensed Professional Clinical Counselor
- Licensed Psychologist
- Licensed Psychological Associate
- Licensed Psychological Practitioner
- Licensed Pharmacist
- Licensed Physical Therapist
- Licensed Practical Nurse
- Licensed Speech Pathologist
- Licensed Speech Therapist
- Nursing Facility
- Ophthalmic Dispenser
- Physician Assistant
- Psychiatric Facility
- Registered Nurse
- Respiratory Therapist
- Substance Abuse Treatment Facility

QUALIFIED TREATMENT FACILITY
A facility, institution or clinic duly licensed by the appropriate state agency, and is primarily established and operating within the scope of its license.

REGISTERED NURSE FIRST ASSISTANT

A nurse who:

A. Holds a current active registered nurse licensure;
B. Is certified in perioperative nursing; and
C. Has successfully completed and holds a degree or certificate from a recognized program, which shall consist of:
    1. The Association of Operating Room Nurses, Inc., Core Curriculum for the Registered Nurse First Assistant; and
    2. One year of postbasic nursing study, which shall include at least forty-five (45) hours of didactic instruction and one hundred twenty (120) hours of clinical internship or its equivalent of two college semesters.
D. A registered nurse who was certified prior to 1995 by the Certification Board of Perioperative Nursing shall not be required to fulfill the requirements of paragraph C of this subsection.

RESPITE CARE

Care which is necessary to provide temporary relief from caregiving responsibilities, to support caregivers who are actively involved in providing the care required by a Covered Person, and whose continuing support is necessary to maintain the individual at home.

SERIOUS MENTAL CONDITION or SIGNIFICANT BEHAVIORAL PROBLEM
This definition only applies to the dental anesthesia and facility benefit services.

A condition

A. Identified by a diagnostic code from the most recent edition of the:
    1. International Classification of Disease-Clinical Modification, including only diagnosis codes which range from 290 through 299.99, 300 through 316, and 317 through 319; or
    2. Diagnostic and Statistical Manual of Mental Disorders; and
B. In a person whose:
    1. Inability to cooperate during dental care by a dentist performed in a location other than a hospital or ambulatory surgical facility can reasonably be inferred from the person's diagnosis and medical history; or
    2. Airway, breathing, or circulation of blood may be compromised during dental care by a dentist performed in a location other than a hospital or ambulatory surgical facility.

SERIOUS PHYSICAL CONDITION
This definition only applies to the dental anesthesia and facility benefit services.

A disease or condition requiring ongoing medical care that may cause compromise of the airway, breathing or circulation of blood during dental care by a dentist performed in a location other than a hospital or ambulatory surgical facility.

SERVICE AREA

The geographic area in which the Plan is authorized to provide or arrange for delivery of Covered Services to Members.

SINGLE COVERAGE
Coverage for the Subscriber only.

SKILLED NURSING CARE
Care needed for medical conditions that require care by skilled medical personnel such as registered nurses or professional therapists. Care must be available twenty-four (24) hours per day, ordered by a Physician, and usually involves a treatment plan.

SKILLED NURSING FACILITY
A Provider that is primarily engaged in providing Skilled Nursing Care and related services to an Inpatient requiring convalescent and rehabilitative care. Such care is rendered by or under the supervision of a Physician and eligibility for payment is based on care rendered in compliance with Medicare-established guidelines. The facility must be operated in accordance with the laws of the jurisdiction in which it is located. A Nursing Facility is not, other than incidentally, a place that provides:

A. minimal care, Custodial Care, ambulatory care, or part-time care services; and
B. care or treatment of Mental Health Conditions, alcoholism, drug abuse, or pulmonary tuberculosis.

SMALL EMPLOYER
This definition only applies to Small Employer Groups.

An employer who, in connection with a group health plan, with respect to a Calendar Year and a Plan Year, employed an average of at least two (2) but not more than fifty (50) employees on business days during the preceding calendar year and who employs at least two (2) but not more than fifty (50) employees on the first day of the plan year; or an affiliated group or association with two (2) to fifty (50) members who meet the eligibility requirements.

SOUND NATURAL TOOTH
A virgin or unrestored tooth, or a tooth which has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant, and functions normally in chewing and speech.

SPECIAL CIRCUMSTANCE
Circumstance in which a Covered Person has a disability, a congenital condition, a life-threatening illness, or is past the twenty-fourth (24^{th}) week of pregnancy, where a disruption of the covered person's continuity of care could cause medical harm.

SPECIAL ENROLLMENT PERIOD
A period of time during which an Eligible Person or Dependent, whether previously enrolled or not, who loses coverage or incurs a change in his or her family status may enroll in the Plan without being considered a Late Enrollee.

STABILIZE
The provision of medical treatment to You in an Emergency as may be necessary to assure, within reasonable medical probability that material deterioration of Your condition is not likely to result from or during:

A. Your discharge from an emergency department or other Emergency Care

setting to another facility; or

B. Your transfer from an emergency department or other Emergency Care setting to the Hospital's Inpatient or other Outpatient setting for non-emergent care.

SUBSCRIBER
An employee who lives or works in the Plan's Service Area and whose employment or other status as determined by the Employer Group meets the eligibility requirements to enroll for coverage under this Certificate which are set forth in the Group Contract, including any applicable waiting period.

SUBSTANCE ABUSE
This term includes alcoholism; or dependence, addiction or abuse of alcohol, chemicals or drugs.

SUBSTANCE ABUSE TREATMENT FACILITY
A Provider that is primarily engaged in providing detoxification and rehabilitation treatment for Substance Abuse. The facility must be operated and licensed in accordance with the laws of the jurisdiction in which it is located and provides treatment by or under the care of Physicians and Nursing Services whenever the patient is in the facility.

TELEHEALTH SERVICES
The use of interactive audio, video, or other electronic media to deliver health care. It includes the use of electronic media for diagnosis, consultation, treatment, transfer of medical data, and medical education. A telehealth consultation shall not be reimbursable if it is provided through the use of an audio-only telephone, facsimile machine, or electronic mail.

THERAPY SERVICE
Services or supplies used for the treatment of an acute illness or Accidental Injury to promote the recovery of the patient. Some Therapy Services include:

A. Physical therapy - The treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, biomechanical and neurophysiological principles, and devices to relieve pain, restore maximum function, and prevent disability following disease, Accidental Injury, or loss of a body part.

B. Occupational therapy - The treatment program of prescribed activities, emphasizing coordination and mastery, designed to assist a person to regain independence, particularly in the normal activities of daily living.

C. Speech therapy - The treatment rendered to restore speech loss due to illness or Accidental Injury.

D. Cardiac rehabilitation - Treatment provided to individuals who have suffered a heart attack or a cardiac revascularization procedure.

E. Chiropractic Therapy – Treatment focused on disorders of the musculoskeletal system and the nervous system, and the effects of these disorders on general health. Chiropractic care is used most often to treat neuromusculoskeletal complaints, including but not limited to back pain, neck pain, pain in the joints of the arms or legs and headaches. The most common therapeutic procedure performed is "spinal manipulation," also called "chiropractic adjustment." The purpose of manipulation is to restore joint mobility by manually applying a

controlled force into joints that have become hypomobile – or restricted in their movement – as a result of a tissue injury.

TOTAL DISABILITY or TOTALLY DISABLED
The continuing inability as a result of injury or illness to perform the material duties or to substantially engage in the duties of any occupation or other gainful activity for which the Covered Person is qualified or could reasonably become qualified to perform by reason of education, training, or experience. For Covered Persons who are not otherwise employed, Total Disability means the inability to engage in the normal activities of daily living for an individual of like age and gender by reason of any injury or illness that can be expected to be of a continuous or indefinite duration.

URGENT CARE
An Urgent Care medical problem is an unexpected episode of illness or an injury requiring treatment that cannot reasonably be postponed for regularly scheduled care, is not life-threatening, and does not require the use of an emergency room.

USUAL, CUSTOMARY AND REASONABLE (UCR) AMOUNT
UCR Amount is the amount that the Plan determines to be the Eligible Expense for a service. The Eligible Expense is determined by the healthcare service or procedure being performed and the usual amount paid for this procedure.

If You go to a Participating Provider, You will be responsible for any Copayment, Coinsurance and/or Deductible amount. You will not be responsible for any amount billed over the UCR amount. In other words, You will not be balance-billed by Your Provider.

However, if You go to a Non-participating Provider, You will be responsible for Your Copayment, Coinsurance and/or Deductible amount, PLUS any amount that the Non-participating Provider bills that is above the Plan's UCR amount. This means that You can be balance-billed by Your Provider. If You use a Non-participating Provider, You may have Your Provider submit a pre-determination of benefits request to the Plan's Customer Service Department. This will provide You with an estimate of the Plan's payment prior to receiving services.

WAITING PERIOD
The period of time before an individual becomes eligible for coverage under the Plan.

WE (US, OUR)
Bluegrass Family Health.

YOU (YOUR)
Any Covered Person.

ELIGIBILITY & ENROLLMENT

ELIGIBILITY

Subscriber Eligibility. To be eligible for coverage as a Subscriber, an individual must be an active, permanent employee who lives or works in the Plan's Service Area and meets the eligibility requirements, including Actively At Work standards, and any applicable waiting period as determined by the Group. The specific time periods and other standards for participation in the Group's benefit plan are determined by the Group, or state and/or federal law, and approved by the Plan.

Dependent Eligibility. To be eligible for coverage as a Dependent of a Subscriber, an individual must be the lawful spouse of a Subscriber, a Dependent child of a Subscriber, or a young adult child under the age of twenty-six (26). Eligibility for coverage is not based on financial dependency, residency, student status, marital status, or employment. A "child" means a newborn child, a stepchild, a child legally placed for adoption, a legally adopted child, a child for whom legal guardianship has been awarded, or a child for whom the Subscriber has a legal obligation under a divorce decree or other court order, including a qualified medical child support order, to provide health care coverage for a child. A newborn child will be covered from the moment of birth for the first thirty-one (31) days of life. To continue coverage of a newborn thereafter, the Subscriber must comply with the Special Enrollment Period requirements under this section of the Certificate; otherwise coverage for the child will cease. A Subscriber required by a court or administrative order to provide health coverage for a child must submit proof of such order at the time application for the child is made. Temporary custody is not sufficient to establish eligibility under this Certificate. Any foster child who is eligible for benefits provided by any governmental program or law will not be eligible for coverage under the Certificate unless required by the laws of this state.

Grandfathered Group Health Benefit Plan Exclusion. Young adult coverage is not available for an adult child if that child is eligible to enroll in an employer-sponsored health plan other than the group plan of the parent.

Extended Coverage for Disabled Dependent Child. Eligibility may continue past the age limit for an unmarried Dependent child covered under the Certificate who is incapable of self-sustaining employment because of mental retardation or mental or physical disability; and chiefly dependent upon the Subscriber for support and maintenance. The Dependent child's disability must start before the end of the period they would become ineligible for coverage. The Subscriber must provide the Plan with proof of the Dependent child's incapacity and dependency, including without limitation that such incapacity and dependency began prior to the date the child reached the limiting age, and that the child is allowed as a federal tax exemption by the Subscriber or Subscriber's spouse, within thirty-one (31) days of the child's attainment of the limiting age. The Plan may request additional proof of continuing incapacity and dependency once per year.

Pre-existing Condition Exclusion Periods. For Members of a Small Employer Group, Pre-existing Conditions are not covered by Us for a period of twelve (12) months from the Enrollment Date, or eighteen (18) months from the Enrollment Date for Late Enrollees.

BFH shall credit the time the Enrollee was covered under other Creditable Coverage if the coverage was continuous to a date not more than sixty-three (63) consecutive days prior to the Enrollment Date under this Certificate. Eligibility waiting periods are not considered in determining a break in coverage.

The Exclusion Period for coverage of a Pre-Existing Condition does not apply to the following: Enrollees under the age of nineteen (19), pregnancy, genetic information in the absence of a diagnosis, or a claim resulting from domestic violence.

If You are an Inpatient on Your Enrollment Date and Your Inpatient stay is covered under a prior plan, services related to the Inpatient stay are not covered under this Certificate. All other Covered Services are covered as of Your Enrollment Date.

If You have prior coverage that has been required by state law to extend benefits for a particular condition or a disability as defined by state law, services for the condition or disability will not be covered under this Certificate.

ENROLLMENT

Eligible Persons and their eligible Dependents who apply for coverage on or before the Employer Group's Effective Date with BFH will begin coverage on the Effective Date which will also be their Enrollment Date. Eligible Persons and their eligible Dependents who become eligible on or after the Employer Group's Effective Date with BFH and who apply for enrollment within thirty-one (31) days from the date they become eligible, will be covered as of their Enrollment Date. An Eligible Person (and any eligible Dependent) who does not enroll within thirty-one (31) days of his or her first date of eligibility must wait until the Group's next open enrollment period to apply for coverage, or to change coverage.

SPECIAL ENROLLMENT PERIOD

Special Enrollment Period means a special thirty-one (31) day enrollment period during which an Eligible Person or eligible Dependent, whether previously enrolled or not, may enroll under this Certificate following the loss of other health care coverage or attaining special eligibility status.

A. **Individuals Losing Other Coverage**. An Eligible Person or their eligible Dependent, who did not enroll under the terms of the Group Contract including this Certificate during the initial enrollment period, may enroll for coverage under the terms of the Group Contract including this Certificate if each of the following conditions is met:
   1. The Eligible Person or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Certificate was previously offered;
   2. The Eligible Person stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment under this Certificate;
   3. The Eligible Person's or Dependent's coverage described in A(1) above:
      a. Was under a COBRA continuation provision and the coverage under such provision was exhausted; or

b. Was not under a COBRA continuation provision and either the coverage was terminated due to loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions toward such coverage were terminated; and

4. The Eligible Person requests enrollment for themselves and/or their eligible Dependent during the Special Enrollment Period which begins upon the date of exhaustion of COBRA continuation coverage, or the date of termination of coverage or employer contributions toward such coverage.

B. **Dependents**.

If a Subscriber, (or an Eligible Person who did not enroll during a previous enrollment period), acquires a Dependent through marriage, birth, or adoption or placement for adoption (the "Qualifying Event"), the Dependent may be enrolled under the Certificate and, in the case of the birth or adoption of a child, the spouse of the Subscriber or Eligible Person may also be enrolled as a Dependent if otherwise eligible for coverage.

For an eligible Dependent to be covered as of the date of the Qualifying Event, or in the case of a newborn or newly adopted child, to continue coverage beyond the thirty-one (31) days following the Qualifying Event, a written request for coverage of the Dependent, and any additional premium or other charge for the additional coverage of the Dependent, must be received by BFH during the thirty-one (31) day Special Enrollment Period. The Special Enrollment Period begins upon the date of the Qualifying Event.

If an otherwise eligible employee named in a Qualified Medical Child Support Order (QMCSO) is not currently enrolled, and the Plan determines the QMSCO is qualified and required to provide coverage to the child, the child must be covered. Since, as a condition for covering Dependents, the employee must be enrolled, then both the employee and child must be permitted to enroll in the Plan.

Newly eligible Dependents that are not enrolled during the thirty-one (31) day Special Enrollment Period may not be added until the Employer Group's next open enrollment period.

MEMBER INFORMATION

Upon Enrollment, an Enrollee will receive an Identification (ID) card. The Enrollee will also be notified of the availability of a copy of this Certificate of Coverage including the Schedule of Benefits available under the Certificate and a current directory of Participating Providers. An updated Participating Provider directory will be available to the Enrollee annually at the beginning of the Certificate Year, as long as the Enrollee continues to be covered under the Certificate. Enrollees may obtain updated Participating Provider information more often by contacting Customer Service, or by logging on to the BFH website at www.bgfh.com.

NOTICE OF CHANGES

The Subscriber is responsible for notifying the Employer Group of any changes that will affect his or her eligibility or that of Dependents. **We must be notified by the Employer Group or the Subscriber of any changes as soon as possible, but no later than within thirty-one (31) days of the event.** This includes changes in address, marriage, divorce, death, change of Dependent disability or dependency status, enrollment or disenrollment in another health plan or Medicare. **Failure to notify Us of persons no longer eligible for services will not obligate Us to pay for such services. Acceptance of premium payments from the Employer Group for persons no longer eligible for services will not obligate Us to pay for such services.**

Family coverage should be changed to Single Coverage when only the Subscriber is eligible. When notice is provided within thirty-one (31) days of the event, the Effective Date of coverage is the event date causing the change to Single Coverage. The Plan must be notified when a Subscriber becomes eligible for Medicare.

An Enrollee's coverage terminates on the date such member ceases to be in a class of Enrollees eligible for coverage. **The Plan has the right to bill the Subscriber for the cost of any services provided to such person during the period such person was not eligible under the Subscriber's coverage.**

Employees and dependents who are eligible but not enrolled for coverage under an employer plan may enroll in two additional circumstances: 1) the employee's or dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; and 2) the employee or dependent becomes eligible for a Subsidy under Medicaid or CHIP. The employee or dependent must request coverage within sixty (60) days after the employee or dependent is terminated from, or determined to be eligible for, such assistance. Note that this period is different than the existing special enrollment rules (for loss of private plan coverage and changing family events such as birth or marriage) under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

TERMINATION, CONTINUATION & CONVERSION

TERMINATION OF COVERAGE

The Subscriber's coverage will terminate on the earliest of the following dates:

A. The date the Subscriber ceases to be in a class of Eligible Persons or ceases to qualify as an Eligible Person. The Employer Group must notify Us immediately if You cease to meet the eligibility requirements. The Employer Group and/or You shall be responsible for payment of any services incurred by You after You cease to meet eligibility requirements;

B. The last day for which the Employer Group has made any required premium contribution for coverage on the Subscriber's behalf;

C. The date the Subscriber is unable to establish and maintain a reasonable patient-physician relationship with a Participating Physician, which includes noncompliance with the prescribed medical treatment plan;

D. The date the Subscriber has engaged in intentional and abusive noncompliance with the Plan Rules or other material provisions of the Certificate;

E. The date You behave in a violent or abusive manner towards Us or a Participating Provider;

F. The date You fail to cooperate with Us in the administration of Your benefits under the Certificate; or

G. The date the Group Contract is terminated.

A covered Dependent's coverage will terminate on the earliest of the following dates:

A. The date the Subscriber's coverage terminates;

B. The date the Dependent no longer qualifies as a Dependent;

C. The date the Subscriber ceases to be in a class of Eligible Persons who are eligible for Dependent insurance;

D. The last day for which the Employer Group has made any required premium contribution for Dependent insurance on the Dependent's behalf;

E. The Dependent is unable to establish and maintain a reasonable patient-physician relationship with a Participating Physician;

F. The date the Dependent insurance benefit is terminated;

G. The Dependent has engaged in intentional and abusive noncompliance with the Plan Rules or other material provisions of the Certificate; or

H. The date the Group Contract is terminated.

TERMINATION FOR CAUSE

We will terminate Your coverage for cause as may be permitted by applicable law, such as, Your perpetrating fraud against Us by, for example:

A. Allowing an unauthorized person to use Your ID card;

B. Using Your ID card for an unauthorized person;

C. Making any false statement or intentional misrepresentations in order to obtain services or a higher level of benefits. This includes actions such as falsifying,

fabricating and/or altering Your application, a claim, a prescription, Your medical records, or Your ID card.

Termination for any of the reasons given above will be effective on the date the fraudulent activity was initiated. A thirty-one (31) day advance written notice of termination will be mailed stating no further claims will be paid for You or any of Your Dependents. We will also terminate Your Dependent's coverage, effective on the date Your coverage was terminated.

GRACE PERIOD FOR UNPAID PREMIUMS

Cancellation due to nonpayment of Premium will be communicated to the Employer Group at least thirty-one (31) days prior to the date of cancellation. The Employer Group must then promptly mail to each Subscriber a copy of the termination notice. If premium is not paid by the premium due date, We will allow for a thirty-one (31) day grace period for which payments can be paid by the Employer Group prior to termination of the policy. If cancellation for nonpayment of Premium occurs, the coverage will automatically terminate on the last date through which Premium was paid. If the Group Contract has been canceled, We will notify each Subscriber who is a Member of a Small Employer Group of the right to conversion within fifteen (15) business days after the end of the thirty-one (31) day grace period. For Subscribers receiving coverage through COBRA or state continuation, We will send notification for termination due to nonpayment of Premium to Your last known address in the Our records.

If We fail to provide the thirty-one (31) days' notice required by this section, Your coverage shall remain in effect at the existing Premium until thirty-one (31) days after the notice is given or until the Effective Date of replacement coverage obtained by You, whichever occurs first.

REINSTATEMENT POLICY

We will not deny a Group Contract reinstatement after cancellation for nonpayment of Premium based on any health-related factor or consideration of medical loss ratio.

FAMILY AND MEDICAL LEAVE ACT OF 1993

An Enrollee who otherwise would be ineligible due to a Subscriber's inactivity at work will retain eligibility during a period of leave under the Family and Medical Leave Act of 1993 (the Act). Enrollment may continue, at the Subscriber's discretion, for the period of leave under the Act.

If the Subscriber does not retain coverage during the leave period, the Subscriber and any eligible Dependents who were covered immediately prior to the leave may be reinstated upon return to work without medical underwriting and without imposition of an additional waiting period for Pre-existing Conditions. To obtain coverage for a former Subscriber upon return from leave under the Act, the Employer Group must provide evidence satisfactory to BFH documenting the applicability of the Act to the Subscriber.

CONTINUATION COVERAGE

State Continuation of Group Coverage

If Member is no longer eligible for coverage under this Certificate, he or she may choose to continue the Group coverage for up to eighteen (18) months after the date of termination. The former Member has up to thirty-one (31) days from the date of notice to apply for continued Group coverage and to pay the first applicable Premium payment. If We fail to give the former Member written notice of the right, We will give written notice to the former Member as soon as practicable after being notified of Our failure to give written notice. The former Member will have an additional period within which to exercise continuation or conversion rights. The additional period shall expire sixty (60) days after written notice is received from the insurer; however, We are not required to give notice or provide continuation coverage to a former Member ninety (90) days after termination of the former Member's group coverage. Written notice delivered or mailed to the last known address to the former Member will constitute giving notice. Failure of the former Member to make the required Premium payments relieves the Plan of any further liability.

The right to continue Group coverage is not available if 1) the Group Contract terminates and is not replaced by another group policy within thirty-one (31) days of the termination date; 2) the Member is eligible for similar group coverage, either on an insured or an uninsured basis; 3) the Member was not covered by the Group Contract and any prior plan replaced by the Group Contract for at least three (3) months prior to the date of termination of his or her coverage; 4) the Member is eligible for Medicare; or 5) the Member is eligible for the federal continuation of coverage option (COBRA).

If Dependent coverage was in effect at the time the Member's Certificate was terminated, then Dependent coverage may be continued for any Dependent covered by the Group Contract. Dependents are eligible for continuation of Group coverage as a result of the Member's death or eligibility for Medicare, the Member's divorce from his or her spouse, or, with respect to a Dependent child only, the child's ineligibility for Group coverage due to reaching the age limit. This Group continuation coverage for Dependents is subject to the same terms and conditions as are applicable to the Member.

Continued coverage will terminate on the earliest of the following dates: 1) the last day of the eighteenth (18^{th}) month after the date the Covered Person is no longer eligible for coverage under the Group Contract; 2) the date the Covered Person fails to make any required Premium payment; 3) the date the Group Contract terminates and is not replaced within thirty-one (31) days; and 4) as to a Dependent child, the date the child no longer qualifies as a Dependent. If a group policy is replaced, by a succeeding Insurer, persons under the continued group health insurance shall remain covered under the prior Insurer's policy until it terminates in accordance with this section. Once continuation of Group coverage terminates, a Covered Person may elect to convert to an individual conversion policy.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

The Consolidated Omnibus Budget Reconciliation Act (commonly known as COBRA) requires that employers with twenty (20) or more employees in the preceding calendar year who sponsor group health plans to offer their employees and their eligible Dependents the opportunity to continue their Group coverage under certain circumstances. If COBRA applies to an Employer Group, any Subscriber whose coverage under this Certificate has been terminated due to one of the following qualifying events: 1) termination of employment (other than for gross misconduct), 2) a reduction in the number of hours worked, or his or her employer's filing of bankruptcy proceedings, is entitled to the continuation of the Employer Group's existing benefits at a Premium rate not to exceed one hundred two percent (102%) of the current Group rate.

Continuation of Group coverage is available to a Subscriber's spouse and Dependent children who lose coverage as a result of one of the following qualifying events: 1) the Subscriber's termination of employment (except for gross misconduct), 2) the Subscriber's death, 3) the Subscriber's entitlement to Medicare benefits, 4) the divorce or legal separation of the spouse from the Subscriber, or 5) with respect to a Dependent child, the loss of Dependent eligibility. The Premium rate applicable to continued coverage for spouses and Dependent children is one hundred two percent (102%) of the existing Group rate for Dependent coverage.

Continuation of Group coverage will terminate on the earliest of the following dates:

A. Eighteen (18) months from the date the Enrollee's coverage otherwise would have terminated under this Certificate because of the Subscriber's termination of employment or reduction in hours worked. If You are receiving an eighteen (18) month maximum period of continuation coverage, You may become entitled to an eighteen (18) month extension (giving a total maximum period of **thirty-six** (**36) months** of continuation coverage) if You experience a second qualifying event that is the death of a Subscriber, the divorce or legal separation of a Subscriber and spouse, a Subscriber becoming entitled to Medicare, or a loss of Dependent child status under the Employer Group's employee benefit plan, and therefore, the Group Contract. The second (2^{nd}) event can be a second (2^{nd}) qualifying event only if it would have caused You to lose coverage in the absence of the first (1^{st}) qualifying event. You must notify BFH of the second (2^{nd}) qualifying event within sixty (60) days of the date on which the qualifying event occurs;
B. Thirty-six (36) months from the date the Enrollee's coverage otherwise would have terminated under this Certificate because of the Subscriber's death, divorce or legal separation, entitlement to Medicare benefits, or the Dependent child's loss of Dependent eligibility;
C. Upon death, for a retired Subscriber who was continuing coverage due to the Employer Group's bankruptcy, and thirty-six (36) months from the date of the Subscriber's death for a Enrollee who is a surviving spouse;
D. The date the Enrollee is entitled to Medicare benefits;
E. The date the Enrollee becomes covered under other group coverage, unless such other group coverage excludes or limits benefits for a Pre-Existing

condition. However, if such other group coverage excludes or limits benefits for a Pre-Existing condition and the Enrollee has Creditable Coverage, which does not exclude or limit benefits for such Pre-Existing condition, the Continuation of Group coverage may be terminated;

F. Twenty-nine (29) months from the date of a qualifying event if the Enrollee is disabled under Title II or XVI of the Social Security Act (SSA) within the first (1st) sixty (60) days of COBRA continuation coverage, and the disability continues for the rest of the eighteen (18) month period of continuation coverage. The disabled qualified beneficiary or another person on his or her behalf must also notify BFH of the SSA determination within sixty (60) days, starting from the latest of: 1) the date on which SSA issues the disability determination; 2) the date on which the qualifying event occurs; or 3) the date on which the qualified beneficiary receives the COBRA general notice. The right to the disability extension may be terminated if the SSA determines that the disabled qualified beneficiary is no longer disabled. The qualified beneficiary receiving the disability extension must notify BFH within thirty (30) days of said SSA determination. One hundred fifty percent (150%) of the applicable Premium may be charged for coverage for the last eleven (11) months of the continuation period;
G. The date through which the Enrollee has timely paid the applicable Premium;
H. The date the Group Contract is terminated. If the Employer Group has other group health coverage, the Enrollee may be eligible to continue benefits under the other health coverage.

In order to satisfy its obligations under the law with regard to continuation of Group coverage, the Employer Group must: 1) notify all Enrollees of their right to continued Group coverage, as required by COBRA; 2) notify BFH as soon as possible of a qualifying event and of the selection by an Enrollee of continued Group coverage and his or her Effective Date of such coverage; and 3) collect and forward to BFH all Premiums on a timely basis.

In order to obtain COBRA coverage under this Certificate, an Enrollee must: 1) notify and provide documentation to the Employer Group within sixty (60) days of a divorce or legal separation of the Subscriber from his or her spouse, a change in a Dependent child's dependency status, or a Social Security disability determination; 2) request in writing the continuation of Group coverage within sixty (60) days after notice of that right has been given by the Group (or BFH if applicable); and 3) pay the first applicable Premium to the Group (or BFH if applicable) within forty-five (45) days of the date of election of COBRA coverage and all subsequent Premiums within thirty (30) days of the due date.

An Enrollee whose continued Group coverage terminates at the end of the maximum coverage period will be eligible for conversion benefits. Notice of the right to conversion coverage must be given to the Enrollee within one hundred eighty (180) days prior to the expiration of the COBRA coverage.

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA):

In the event You are absent from Your employment by reason of service in the Armed Forces of the United States, You may elect to continue coverage for You and

Your Dependents. The maximum period of Your and Your Dependents' coverage under this continuation coverage shall be the lesser of either the twenty-four (24) month period beginning on the date on which Your absence due to military service begins; or the day after the date on which You fail to apply for, or return to, Your position of employment.

If You elect to continue coverage under this section, You will be required to pay one hundred two percent (102%) of the full premium due under the Group Contract, except that if Your military service is for less than thirty-one (31) days, You may not be required to pay more than the active Subscriber share, if any, for continuation of coverage.

If You return to Your employment following military service, Your and Your Dependents' coverage may be reinstated without application of any exclusion or waiting period.

CONVERSION BENEFITS

Any Member who has been covered under this Certificate, or any Group coverage it replaced, for at least three (3) months may convert to an individual conversion policy upon the termination of this Certificate. Conversion health insurance coverage shall be available without evidences of insurability and may contain a pre-existing condition limitation. The Member will be offered a conversion policy at his or her last known address. The conversion policy benefits will be substantially similar to those provided by the group policy. The initial Premium and written application for the conversion coverage must be received by the Plan no later than: 1) thirty-one (31) days after the termination of Group coverage if proper notice of the right to conversion has been furnished to the Member, or 2) if no written notice has been given to the Member at the termination of membership in the Group plan, then fifteen (15) days after the Member has actually been provided written notice of the existence of the conversion rights, but 3) in no event, later than an additional sixty (60) days after the expiration of the initial thirty-one (31) day period described in (1) above.

Conversion coverage is also available to a covered surviving spouse and Dependent children upon the death or divorce of the Member or upon termination of a Dependent child's eligibility due to his or her attaining the age limit under the Group Contract.

Conversion coverage is not available to a Covered Person eligible for or covered by Medicare benefits or another policy providing similar benefits, or if issuing the conversion policy will make the Covered Person over-insured according to the Plan's rules. Newly acquired Dependents are not eligible for conversion coverage if the Dependent was not covered under the group policy on the date coverage under the group policy terminated.

The Subscriber's Conversion coverage will terminate on the earliest of the following dates:

A. The last day for which the Subscriber has made any required premium contribution for coverage on Your behalf;

B. The date the Subscriber is unable to establish and maintain a reasonable patient-physician relationship with a Participating Physician, which includes noncompliance with the prescribed medical treatment plan;
C. The date the Subscriber has engaged in intentional and abusive noncompliance with the Plan Rules or other material provisions of the Certificate;
D. The date You behave in a violent or abusive manner toward Us or a Participating Provider;
E. The date You fail to cooperate with Us in the administration of Your benefits under the Certificate; or
F. The date the Group Contract is terminated.

A covered Dependent's coverage will terminate on the earliest of the following dates:

A. The date the Subscriber's coverage terminates;
B. The date the Dependent no longer qualifies as a Dependent;
C. The last day for which the Subscriber has made any required premium contribution for Dependent insurance on the Dependent's behalf;
D. The Dependent is unable to establish and maintain a reasonable patient-physician relationship with a Participating Physician;
E. The date the Dependent insurance benefit is terminated;
F. The Dependent has engaged in intentional and abusive noncompliance with the Plan Rules or other material provisions of the Certificate; or
G. The date the Group Contract is terminated.

PLAN DELIVERY SYSTEM RULES

If Plan Delivery System Rules are not followed, Your claims will be denied.

The Plan Delivery System Rules are the guidelines for the use of the Plan's health care delivery system. **Benefits will be denied for failure to follow these provisions. The Plan Delivery System Rules apply regardless of whether or not the Plan is primary payer, secondary payer, etc. No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of this certificate**.

COVERED and NON-COVERED SERVICES

Benefits are payable only for services that are considered to be a Covered Service and are subject to the specific conditions, duration limits and applicable maximums of the Certificate. Refer to Your Schedule of Benefits for the applicable deductibles, copayments, and/or coinsurance amounts for Covered Services.

If You receive non-covered services, whether from a Participating or Non-Participating Provider, You are responsible for making the full payment to the Provider. The fact that a Provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a bodily injury, sickness, or psychiatric disorder, does not mean that the procedure or treatment is covered under the Certificate. Please refer to Your Schedule of Benefits and the Exclusions section for more information about covered and non-covered services.

IN-NETWORK BENEFITS

In-Network benefits apply to Covered Services that are obtained from Participating Providers. You are responsible for verifying that the Providers You see are Participating Providers with BFH. To verify that a Provider is Participating with the Plan, visit Our website at www.bgfh.com or call Customer Service.

If You go to a Participating Provider, You will be responsible for any Copayment, Coinsurance and/or Deductible amount. You will not be responsible for any amount billed over the Eligible Expense(s) for Covered Services, except when You fail to follow the Plan Delivery System Rules.

Regardless of Medical Necessity, benefits will not be provided for services that are excluded from coverage or are not a Covered Benefit, even when a Participating Provider performs the services, e.g. cosmetic surgery. You may be billed by Participating Provider(s) for any Non-Covered Services You receive or when You have not acted in accordance with this Certificate.

For services that require PA, the Plan must approve the service(s) before those services are obtained. For a list of services that require PA, visit Our website at www.bgfh.com or call Customer Service. **If approval is not issued prior to the service being obtained, benefits will be denied.**

OUT-OF-NETWORK BENEFITS

Out-of-Network benefits apply to Covered Services that are obtained from Non-Participating Providers. Please refer to Your Schedule of Benefits or contact Customer Service to determine if Out-of-Network benefits are provided in Your plan.

If Your plan does not provide Out-of-Network benefits, services provided by an Out-of-Network Provider will be denied, unless determined by BFH to be of an Urgent and/or Emergent nature.

If Your plan does provide Out-of-Network benefits and You go to a Non-Participating Provider, You will be responsible for Your Copayment, Coinsurance and/or Deductible amount. In addition, since Non-Participating Providers have not agreed to accept Our negotiated fees as payment in full, they may balance bill You for charges in excess of the Eligible Expense. You will be responsible for this amount in addition to any applicable Deductible, Copayment and/or Coinsurance amounts. **This means that You may pay significantly more for services received under the Out-of-Network Benefit.** Any amount You pay to the Provider in excess of Your applicable Coinsurance or Deductible will not apply to Your Out-of-Pocket Limit. You will also be responsible for payment of services that the Plan determines are Not Medically Necessary, or are excluded from coverage.

PA requirements also apply to Covered Services obtained from Non-Participating Providers. Failure to obtain PA before Covered Services are provided will result in the claim(s) being denied. **You are responsible for verifying if Covered Services have been prior authorized by the Plan.**

PA Referral to Non-Participating Provider. In the event Your Physician determines that You need a particular health care service and the Plan determines that the service is a Covered Service and is not available from any Participating Provider within the Plan's Network, Your Physician should refer You to an appropriate Non-Participating Provider. The Non-Participating Provider should be located within fifty (50) minutes/fifty (50) miles or within a reasonable proximity of Your Primary Residence to the extent those services are available. The Plan should be contacted by Your Physician to make arrangements to ensure coverage prior to receiving the service. Non-Participating Provider visits will be paid at Your Out-of-Network benefit, if applicable, if an authorization is not obtained prior to services being rendered. You are responsible for any applicable Copayment, Coinsurance or Deductibles. **You are also responsible for verifying that Covered Services have been prior authorized by the Plan.**

SPECIAL CIRCUMSTANCES

If a Member is receiving treatment from a Participating Provider and that Provider's agreement to provide Medically Necessary services terminates for reasons other than medical competence, fraud or professional behavior, the Member may be entitled to continue treatment by the terminating Provider if at the time of the Provider's termination the Member is disabled, being treated for a congenital condition, being treated for a life-threatening illness, or is past the twenty-fourth (24^{th}) week of pregnancy.

The treating Provider must contact Us requesting continuity of treatment. The maximum duration of continued treatment may not exceed ninety (90) days from the date of the Provider's termination; nine (9) months in the case of a member diagnosed with a terminal illness; or through the delivery of a child, in the case of a Member past the twenty-fourth (24^{th}) week of pregnancy.

PLAN SERVICE AREA

BFH is a health plan providing access to comprehensive health care services within a specified area, referred to as the Service Area. This Service Area is the geographic region within which the Plan is licensed to operate. In order to enroll in the Plan, You must live and/or work in the counties included in the Service Area.

If You travel or live away from home for an extended period of time, coverage for Non-Urgent and Non-Emergency Care services received outside the Service Area is provided at the Out-of-Network benefit level. If You move outside the Service Area and do not work within it, You may be ineligible for membership or for continued membership. If You anticipate moving outside the Service Area, contact Your employer (benefits administrator or human resources director) or the Plan's Customer Service Department.

ACCESSIBILITY TO HEALTH CARE COVERAGE

To make it easy for You to access Your benefits, You must **always** comply with the following:

- When You join the Plan, You and each participating Member of Your family will receive an ID card. You must show Your current ID card every time You request services. If You do not show Your ID card, Providers have no way of knowing that You are enrolled with BFH. As a result, they may bill You for the entire cost of the services You receive. Benefits are available only if the Covered Health Services are received while the Plan is in effect, and the person who receives Covered Health Services is a Covered Person and meets all eligibility requirements specified in the Plan. Any person receiving benefits or services to which he or she is not entitled will be responsible for any charges incurred. If You lose Your card or need extra cards, please contact Customer Service or logon to My*Bluegrass*Info℠ at www.bgfh.com for replacements.
- Select any Participating Provider from a current Plan Provider list and confirm that the Provider You choose to receive services from is participating with the Plan. Participating Providers are subject to change without notice and Provider updates are available on Our website at www.bgfh.com or by contacting Customer Service.
- Pay all appropriate Deductible, Copayment and/or Coinsurance amounts as listed on Your ID card or on Your Schedule of Benefits.

SECOND OPINIONS

There may be instances when the Plan will require You to obtain a second opinion to assist in determining Medical Necessity. The Plan may assist with scheduling appointments and all related testing. If the Plan requires a second opinion, any Copayments and/or Coinsurance amounts are waived. When a Covered Person obtains a second opinion evaluation not required by the Plan, all Plan Rules apply.

NOT LIABLE FOR PROVIDER ACTS OR OMISSIONS

The Plan is not responsible for the actual care You receive from any person. This Certificate does not give anyone any claim, right, or cause of action against the Plan based on what a Provider of health care, services or supplies, does or does not do.

EMERGENCY SERVICES

Services for Medically Necessary Emergency Care that We determine to meet the definition of Emergency Care will be covered under this Certificate, whether a Participating Provider or a Non-Participating Provider renders the care. These services may include emergency accident care and emergency medical care rendered at a Hospital, such as emergency department screening and stabilization services. **Follow-up care is not considered Emergency Care.**

Benefits are provided for treatment of emergency medical conditions and emergency screening and stabilization services without PA for conditions that reasonably appear to a prudent layperson to constitute an emergency medical condition based upon the patient's presenting symptoms and conditions.

If You are admitted as an Inpatient as a result of an Emergency Medical Condition or directly from a Hospital emergency room, You should have Your Provider contact Us within twenty-four (24) hours of admission or as soon as reasonably possible in order to obtain authorization for a specific length of stay. When Your Provider contacts Us for authorization, Your Provider will be notified of the number of days considered Medically Necessary for Your diagnosis, and You may avoid having to pay charges for any excessive Inpatient days that We do not consider Medically Necessary.

Care and treatment provided once You are Stabilized is not Emergency Care. Continuation of care from a Non-Participating Provider beyond what is needed to evaluate or Stabilize Your condition in an Emergency will be covered at Your Out-of-Network Benefit, if applicable, or will not be covered unless You receive PA for the continuation of care and We deem it to be Medically Necessary.

URGENT CARE SERVICES

If You experience an accidental injury or medical problem, We will determine whether Your injury or illness is an Urgent Care or Emergency Care situation for coverage purposes based on Your diagnosis and symptoms. An Urgent Care medical problem is not an Emergency. An Urgent Care medical problem is an unexpected episode of illness or an injury requiring treatment that cannot reasonably be postponed for regularly scheduled care, is not life-threatening, and does not require the use of an emergency room; or a preadmission review of a hospital admission or preauthorization request for outpatient surgery. Examples of Urgent Care medical problems include fever (less than 104 degrees), ear ache, and sore throat.

TRAVEL OUTSIDE THE COUNTRY

If You are traveling outside of the country, benefits are available for Emergency and Urgent Care only. Seek care at the appropriate facility. Once Your care is completed, You will need to pay the bill. (You may want to use a credit card. The credit card company will automatically transfer the foreign currency into American dollars for You.) Keep all Your receipts. When You return home contact Customer Service at the number on the back of Your ID card. Submit information about Your situation along with Your receipts in order to receive reimbursement. You will be reimbursed based on the benefits of Your Plan. Please refer to the Exclusions section of this Certificate for further information.

PRIOR AUTHORIZATION OF HEALTH CARE SERVICES

Prior Authorization (PA) is a process to determine if certain inpatient and outpatient medical services, as determined by the PA list, meet evidence based criteria for medical necessity and is a benefit under the Member's plan **prior to the service being provided**.

The PA list is available on Our website at www.bgfh.com or by contacting Customer Service. The PA list is subject to change. Notification to Members and Providers will be provided thirty (30) days before a change is made.

You and your Provider are responsible for obtaining PA from the Plan's Healthcare Operations Department in order to receive the maximum benefit available in Your plan. PA applies to all BFH products and must be initiated by the ordering or requesting Provider. PA is required whether BFH is the primary or secondary.

All PAs are based on Medical Necessity and benefit limitations; they are not a guarantee of payment or coverage, payment level or Member eligibility.

PA applies to all BFH products and must be initiated by the requesting Provider.

PENALTY FOR NOT OBTAINING PA

If Your Provider does not obtain PA for services being rendered, Your benefits for both Provider and Hospital or Qualified Treatment Facility shall be denied.

SECOND SURGICAL OPINION

A second surgical opinion may be required, as provided in the Plan, before the confinement will be precertified. Benefits for the second surgical opinion, including any Medically Necessary x-ray and laboratory tests performed by the second Provider shall be considered like any other covered medical expense.

If the two (2) opinions disagree, You may obtain a third (3rd) opinion. Benefits for the third (3rd) opinion are payable the same as for the second (2nd) opinion.

The Physician's providing the surgical opinions MUST NOT be in the same group practice or clinic. The Physician providing the second (2nd) or third (3rd) surgical opinion may confirm the need for surgery or present other treatment options. The decision whether or not to have the surgery is always Yours.

BFH utilizes vendors for certain areas of services that require PA. Your Provider is responsible for contacting the entities listed below for PA.

OptumHealth – Chiropractic Services – OptumHealth is a health care organization that specializes in the delivery of chiropractic services nationwide. Chiropractic services do not require referral, but do require PA. OptumHealth can be reached at (800) 873-4575.

OptumHealth—Mental Health and Substance Abuse—OptumHealth is a health care organization responsible for the management of mental health and substance abuse benefits. Members are required to initiate a call to OptumHealth for all of their mental health/chemical dependency needs. OptumHealth can be reached at (877) 369-2201.

Care Continuum (CC)—Home Health/Home Infusion—CC is a health care organization licensed and organized under the laws of Kentucky, which has been contracted by the Plan to perform PA of Home Health services, such as skilled nursing, therapy (physical, occupational, speech) and infusion therapy. CC can be reached at (877) 700-3482.

MEDICAL TECHNOLOGY ASSESSMENT (New and Emerging)

BFH continually evaluates new and emerging medical technology for benefit inclusion and Medical Necessity. These technologies require PA. Medical technology is a dynamic process; therefore, We cannot be specific to all procedures/services that may be considered as such. Decisions to include medical technology are made after an extensive review of the medical and scientific literature, communication with medical experts as appropriate, and review by the Plan's Utilization Management committee. If You want to clarify a procedure/service that You are having performed requires PA or is a covered benefit, please contact Customer Service at (800) 787-2680 or (859) 269-4475 or visit Our website at **www.bgfh.com**.

PRESCRIPTION DRUGS

Please refer to Your Schedule of Benefits or contact Customer Service to determine if You have prescription medication coverage.

Due to the nature of some medications, PA may be required before the Plan will cover the medication's cost. PAs are based on established clinical guidelines and the patient's medical history and only Providers may request medication PA. If Your physician has prescribed a medication that requires PA, he or she will need to contact the Plan's Pharmacy Services Department by phone 877-205-6308 or by fax 859-335-3744 to obtain an approval **PRIOR** to You receiving the medication. **PA's will not be issued after the prescription has been filled.**

BENEFITS

This section explains health care benefits. Each benefit section shows what services are covered. The Schedule of Benefits gives the amount of benefits payable, as well as any Deductibles, Copayments, Coinsurance, and maximums under Your Certificate.

Subject to the applicable Exclusions, limitations, Plan Delivery System Rules, Healthcare Operations Provisions, and other conditions of the Plan, Covered Persons are entitled to the benefits in this section for Covered Services. Covered Services must be rendered by a Hospital, Physician, or other Provider during each Plan Year. Benefits shall only be provided for services, supplies, and care that are Medically Necessary and consistent with the diagnosis and treatment of an illness or injury, in the amounts specified in the Schedule of Benefits.

Review Your Plan's Delivery System Rules. Benefits may be denied or reduced if these requirements are not followed.

Refer to the Exclusions section of this Certificate for information on health conditions and services that are permanently excluded from coverage under this Plan.

PREVENTIVE SERVICES

A. Well-baby and well-child care including periodic examinations, developmental assessments and anticipatory guidance necessary to monitor the normal growth and development of a child;
B. Adult physical exams;
C. Periodic early detection services;
D. Colorectal cancer exams and applicable laboratory tests.

A complete copy of BFH's Preventive Guidelines List of services that are covered by the Plan is available on Our website at www.bgfh.com or by contacting Customer Service at (800) 787-2680 or (859) 269-4475.

PHYSICIAN SERVICES

Covered Services include:

A. Non-surgical, medical care services rendered by a Physician or other qualified Provider to a Covered Person, for the examination, diagnosis, and treatment of a covered illness or injury;
B. Allergy serum and injections;
C. Contraceptive services provided in the office of a Physician or other qualified Provider;
D. Telehealth services; and
E. Diabetes self-management training and education, including nutrition therapy.

Covered Services must be performed, delivered, or supervised by a Physician or other qualified Provider and must be performed in a manner consistent with prevailing medical standards.

Medical care that is rendered concurrently by different Physicians may be considered for benefits if treatment is for separate medical conditions, or the nature or severity of the medical condition requires the skills of separate Physicians or other Providers. This includes the medical services rendered for the purpose of a

consultation with the attending Physician, exclusive of staff consultations required by any facility rules or regulations.

INPATIENT HOSPITAL SERVICES
Covered Services include:

A. Room and Board when the Covered Person occupies:
   1. A room with two (2) or more beds, known as a semi-private room or ward; or
   2. A private room. The private room allowances shall be limited to an amount equal to the Hospital's average semi-private rate;
   3. A private room for the distinct purpose of medical isolation. Coverage is limited to the period of time for which medical isolation is Medically Necessary. Such cases require specific approval by the Plan; or
   4. A bed in a special care unit, including nursing services - a designated unit which is approved by the Plan and has concentrated facilities, equipment, and supportive services for the provision of an intensive level of care for critically ill patients.

B. Ancillary Services - Hospital services and supplies including, but not restricted to:
   1. Use of operating, delivery, and treatment rooms and equipment;
   2. Prescription drugs administered to an Inpatient;
   3. Administration of blood and blood processing;
   4. Anesthesia, anesthesia supplies and services rendered by an employee of the Hospital or through approved contractual arrangements;
   5. Medical and surgical dressings, supplies, casts, and splints;
   6. Diagnostic Services;
   7. Therapy Services; and
   8. Special care unit nursing services.

INPATIENT MEDICAL CARE
Medical care for conditions not related to Maternity Care or Mental Health Conditions, except as specifically provided. Benefits for inpatient medical care are limited to:

A. Visits by the attending Physician.

B. Intensive medical care - Medical care requiring a Physician's constant attendance.

C. Concurrent medical care
   1. Medical care in addition to surgery during the same admission for unrelated medical conditions. A Physician other than the operating surgeon provides this medical care.
   2. Medical care by two or more Physicians during the same admission for unrelated medical conditions. The medical care must require the skills of separate Physicians.

D. Consultations - Consultations provided by a Physician at the request of the attending Physician. Consultations do not include staff consultations required by Hospital rules and regulations.

OUTPATIENT HOSPITAL / AMBULATORY SURGICAL FACILITY / OTHER OUTPATIENT SERVICES

A. Surgery, which includes facility services and supplies, anesthesia, anesthesia supplies, and services rendered by an employee of the facility other than the surgeon or assistant surgeon, when performed on an Outpatient basis.

B. Ancillary services listed below and furnished to an Outpatient, if approved by the Plan:
   1. Use of operating room and recovery rooms;
   2. Respiratory therapy (e.g. oxygen);
   3. Administered drugs and medicine;
   4. Intravenous solutions;
   5. Dressings, including ordinary casts, splints or trusses;
   6. Anesthetics and their administration;
   7. Transfusion supplies and equipment; and
   8. Diagnostic services, including radiology, ultrasound, laboratory, pathology and approved machine testing, e.g. electrocardiogram (EKG).

C. Observation, an alternative to an inpatient admission that allows the Member's Physician reasonable and necessary time to medically evaluate and provide Medically Necessary services to a Member whose diagnosis and treatment are not expected to exceed twenty-four (24) hours.

THERAPEUTIC SERVICES

The following treatment rendered to an Outpatient:

A. Chemotherapy treatment for proven malignant disease;

B. Radiation therapy: treatment by x-ray, radium or radioactive isotopes;

C. Renal Dialysis Treatment for acute or chronic kidney ailment, which may include the supportive use of an artificial kidney machine; and

D. Intravenous (IV) Therapy: therapeutic, hydration, prophylactic, and diagnostic injections and infusions.

SURGICAL SERVICES

A. Surgery - When performed by a Physician or other covered licensed Provider, coverage includes the usual pre-operative and post-operative care.

B. Assistance at Surgery - Coverage is provided for the Medically Necessary services of an assistant at surgery who actively assists the surgeon in the performance of a covered surgical procedure. The Assistant must be properly credentialed by the facility at which the surgery is performed and be a Physician, a Certified Surgical Assistant, a Registered Nurse First Assistant, or a Physician Assistant. No coverage is available for interns, residents, or facility house staff members who assist.

C. Anesthesia - Coverage is provided for the services of a Physician or other professional Provider other than the surgeon or assistant surgeon, for administration of anesthesia, as ordered by the attending Physician.

EMERGENCY CARE

Benefits are provided for treatment of Emergency Medical Conditions and emergency screening and stabilization services for conditions that reasonably appear to a prudent layperson to constitute an Emergency Medical Condition based upon the patient's presenting symptoms and conditions. Benefits are not provided for the use of an emergency room except for treatment of Emergency Medical Conditions, and emergency screening and stabilization. Services required after the Member has been Stabilized may not be considered Emergency Care. Services rendered after Stabilization will be covered in accordance with the Member's Schedule of Benefits.

If a Covered Person is admitted to a Non-Participating Hospital after receipt of Emergency Care, BFH must be notified within one (1) business day or on the same day of admission if reasonably possible. BFH may require transfer of a Covered Person to a Participating Hospital as soon as medically feasible. If a Covered Person chooses to stay in a Non-Participating Hospital, benefits may not be available.

URGENT CARE

Benefits are provided for Urgent Care when care: 1) Is required to prevent serious deterioration in the Covered Person's health; 2) Could not have been foreseen prior to leaving the Service Area or during normal office hours; 3) Is not an Emergency Medical Condition, but requires prompt medical attention; 4) Includes the treatment of significant injuries as a result of accidents, the relief or elimination of severe pain, or the moderation of an acute illness; and 5) Is obtained in accordance with the Plan Delivery System Rules.

AMBULANCE SERVICES

A. Ambulance service providing transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured:
   1. From a Covered Person's home or scene of accident or medical emergency to the closest facility that can provide Covered Services appropriate to the Covered Person's condition. If there is no facility in the local area that can provide Covered Services appropriate to the Covered Person's condition, Ambulance service means transportation to the closest facility outside the local area that can provide the necessary services;
   2. Between Hospitals if the initial hospital cannot provide the services to treat the member's condition; and
   3. Between a Hospital and Nursing Facility, with PA from the Plan.

B. When approved by the Plan, Ambulance service providing local transportation by means of a specially designed vehicle used only for transporting the sick and injured:
   1. From a Hospital to the Covered Person's home, or
   2. From a Nursing Facility to the Covered Person's home when the transportation would qualify as a Covered Service.

Air Ambulance
Air Ambulance services are covered only when the Plan determines an air Ambulance is Medically Necessary and is the most appropriate means of transportation to safeguard the Member's medical condition during transfer to appropriate medical facility. Air Ambulance usage is not covered when another type of transportation can be used without endangering the Member's health. Any Ambulance usage solely for the convenience of the Member, family, or Physician is not a Covered Service.

BEHAVIORAL HEALTH SERVICES
Behavioral Health Services include coverage for the diagnosis and treatment of Mental Health Conditions and Substance Abuse as outlined below.

Mental Health Services
Services are covered for the diagnosis and treatment of Mental Health Conditions when rendered by a Hospital, Physician, or other applicable Provider, to the extent specified in the Schedule of Benefits, subject to PA and periodic review, as determined by the Plan.

A. Inpatient **-** Inpatient Hospital or Psychiatric Facility services for the treatment of Mental Health Conditions. Benefits are also provided for:
   1. Individual psychotherapy treatment;
   2. Group psychotherapy treatment;
   3. Psychological testing; and
   4. Convulsive therapy treatment.

   Electroshock treatment or convulsive drug therapy, including anesthesia when administered concurrently with the treatment by the same Physician or other professional Provider. If a different Physician or other licensed Provider administers anesthesia, then the anesthesia is considered a separate service.

B. Day Treatment/Intensive Outpatient Program **-** The treatment of a Mental Health Condition in a day treatment/intensive Outpatient program primarily used to assist patients during an acute psychiatric crisis. Benefits for this type of program are available on the same basis as benefits for Inpatients. Two (2) days of treatment in a Day Treatment Program or Intensive Outpatient Program are the equivalent of one (1) day as an Inpatient.

C. Outpatient Therapy **-** The treatment of a Mental Health Condition when rendered by a Hospital, Physician, or other applicable Provider for services to an Outpatient, including individual and group psychotherapy treatment and psychological testing.

For Members of a Small Employer group, benefits are provided for pharmacy care, if covered by the plan, psychiatric care, psychological care, therapeutic care, Applied Behavior Analysis, Habilitative and Rehabilitative care for a Covered Person age one (1) year through twenty-one (21) years of age for the treatment of Autism Spectrum Disorders. The one thousand dollar ($1,000) maximum benefit per month, per Covered Person in accordance with KRS 304.17A-143, shall not apply to other health conditions of the Covered Person or services for the Covered Person not related to the treatment of an Autism Spectrum Disorder.

For Members of a Large Employer group, benefits are provided for the diagnosis and treatment of Autism Spectrum Disorders for a Covered Person age one (1)

year through twenty-one (21) years of age. Coverage shall be subject to a maximum annual benefit per Covered Person as follows:

A. For Covered Persons age one (1) year to seven (7) years, the maximum annual benefit shall be fifty thousand dollars ($50,000) per Covered Person, per year.
B. For Covered Persons age seven (7) years to twenty-one (21) years, the maximum benefit shall be one thousand dollars ($1,000), per month per Covered Person.

These limits shall not apply to other health conditions of the Covered Person or services for the Covered Person not related to the treatment of an Autism Spectrum Disorder.

Substance Abuse

Coverage for Substance Abuse includes individual and group counseling and psychotherapy, psychological testing, and family counseling for the treatment of Substance Abuse, when rendered to a Covered Person by a Hospital, Substance Abuse Treatment Facility, Physician, or other applicable Provider. Benefits are subject to PA and periodic review as established by the Plan.

A. Inpatient - Services rendered to an Inpatient by a Hospital or Substance Abuse Treatment Facility for the treatment of Substance Abuse. Services to an Inpatient shall be authorized only when deemed the least restrictive mode of treatment. Benefits are also provided for:
   1. Individual treatment;
   2. Group treatment; and
   3. Testing.
B. Day Treatment/Intensive Outpatient Program **-** The treatment of Substance Abuse in a day treatment/intensive Outpatient program primarily used to assist patients during an acute crisis. Benefits for this type of program are available on the same basis as benefits to Inpatients. Two (2) days of treatment in a Day Treatment or Intensive Outpatient Program are the equivalent of one (1) day as an Inpatient.
C. Outpatient Therapy **-** The treatment of Substance Abuse when rendered by a Hospital, Substance Abuse Treatment Facility, Physician, or other applicable Provider for services to an Outpatient, including individual treatment, group treatment, and testing.

DENTAL SERVICES

A. ACCIDENTAL:

   Coverage is provided only when services are required due to an external trauma that results in dental damage to a Sound Natural Tooth. The dental damage must be of sufficient significance that initial contact for evaluation shall occur within seventy-two (72) hours of the accident. Definitive treatment services shall be initiated within three (3) months of the accident and completed within twelve (12) months of the accident. No coverage is provided unless the dentist certifies to the carrier that the tooth was a Sound Natural Tooth that was injured as a result of an accident. Incidents related to normal activities of daily living or extraordinary use of one’s teeth are not considered to be accidents. Repairs to teeth that are injured as a result of such activities are

not covered under the Policy. Injury to the teeth as a result of chewing, biting, or bruxism is not considered an Accidental Injury. Dental implants are not covered.

For the purpose of this benefit, accident-related dental services are services performed by a duly licensed physician, Doctor of Dental Surgery (DDS) or Doctor of Medical Dentistry.

B. ANESTHESIA AND FACILITY BENEFIT

Coverage is provided for general anesthesia and hospital or ambulatory surgical facility charges in connection with dental problems for children below the age of nine (9) years, persons with Serious Mental or Physical Conditions, and persons with Significant Behavioral Problems, when certified by the treating dentist or admitting Physician.

DIAGNOSTIC SERVICES

Non-invasive Diagnostic Services, including their interpretation, for the treatment of an illness or injury, may include:

A. X-ray and other radiology/imaging services, including mammograms for any person diagnosed with breast disease;
B. Laboratory and pathology services;
C. Advanced Imaging such as: MRI, MRA, PET, SPECT and CT imaging procedures;
D. Allergy testing; and
E. Cardiographic, encephalographic, and radioisotope tests.

DURABLE MEDICAL EQUIPMENT (DME)

DME is equipment that is primarily and customarily used to serve a medical purpose, can withstand repeated use and is appropriate for use in the home. DME is covered if it is necessary and reasonable for the treatment of an illness or injury or to improve the functioning of a malformed body member.

Coverage for DME includes equipment to assist mobility, such as a standard wheelchair, oxygen and the rental of equipment to administer oxygen, standard hospital-type beds, and mechanical equipment necessary for the treatment of chronic or acute respiratory failure.

DME is limited to the rental (but not to exceed the total cost of purchase) or, at the option of the Plan, the purchase of DME prescribed by a Covered Person's attending Physician for therapeutic use. The rental/purchase includes the necessary fittings, adjustments, and delivery/installation of the DME. Coverage is also provided for necessary repairs to keep such equipment serviceable. If more than one piece of DME can meet Your functional needs, benefits are available only for the most cost-effective piece of equipment.

Replacement coverage for DME may only be considered when the equipment to be replaced can no longer be made serviceable.

Examples of items that are not considered DME and are excluded from coverage include: adjustments made to vehicles, air conditioners, air purifiers, free-standing humidifiers, dehumidifiers, elevators, ramps, stair glides, emergency alert equipment, handrails, heat appliances, improvements made to Your home or place of business, waterbeds, whirlpool baths, exercise and massage equipment, and personal comfort items.

HEARING AIDS AND RELATED SERVICES

Coverage for the full cost of one (1) hearing aid per hearing impaired ear up to one thousand four hundred dollars ($1,400) every thirty-six (36) months for Hearing Aids for insured individuals under eighteen (18) years of age. The hearing aid and all related services must be prescribed by an audiologist and dispensed by a licensed audiologist or hearing instrument specialist. If the insured purchases a hearing aid that costs more than the maximum benefit of one thousand four hundred dollars ($1,400), that maximum benefit will be toward the purchase of the more expensive hearing aid.

Surgery for Cochlear Implants is a covered benefit for persons diagnosed with profound hearing impairment.

HOME HEALTH CARE

Benefits are available for home health care services when ordered by a Physician, provided by or supervised by a registered nurse in Your home, and are necessary to avoid or reduce hospitalization of a Covered Person. Benefits are available only when the Home Health Agency services are provided on a part-time, intermittent schedule and when skilled care is required. Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services that are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient. The Plan will decide if skilled care is required by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver. Services must be ordered by a Physician and require clinical training in order to be delivered safely and effectively.

Certain therapies, including physical therapy, occupational therapy, and speech therapy, when received from a Home Health Agency, do not count towards a Covered Person's Plan Year benefit maximum for Therapy Services. A visit of four (4) hours or less by a home health aide service is considered one (1) home health care visit.

The Plan shall not pay for services that have not been authorized, services not included in the Physician's prescribed treatment Plan, services that are delivered for the purpose of assisting with activities of daily living, include dressing, feeding, bathing or transferring from a bed to a chair, services of an immediate family Member, or Custodial Care.

HOSPICE CARE SERVICES

Hospice services are covered when a Covered Person has been certified by a Physician to be terminally ill, with a life expectancy of six (6) months or less, and elects Hospice coverage in lieu of continued attempts at a cure. Hospice includes services, supplies and care to help provide comfort and relief from pain.

Covered Services may include: Physician services, nursing care, medical appliances and supplies, drugs for an Outpatient for symptom management and pain relief, short term care for Inpatients, Respite Care, home health aides, and homemaker services, physical therapy, occupational therapy, and speech/language pathology services, and counseling, including dietary counseling.

INBORN ERRORS OF METABOLISM OR GENETIC CONDITIONS
A health plan that provides prescription drug coverage shall provide that coverage for the treatment of inborn errors of metabolism or genetic conditions if the therapeutic food, formulas, supplements, and low-protein modified food products are obtained for the therapeutic treatment of inborn errors of metabolism or genetic conditions under the direction of a Physician. Coverage for therapeutic food, formulas, and supplements shall be subject, for each plan year, a cap of twenty-five thousand dollars ($25,000) and low-protein modified food products shall be subject, for each plan year, a cap of four thousand dollars ($4,000), subject to annual inflation adjustments based on the consumer price index.

INFERTILITY SERVICES
Please refer to Your Schedule of Benefits or contact Customer Service to determine if infertility is covered under Your Plan.
If infertility benefits are available, coverage will be provided for the diagnosis and treatment of infertility including services, supplies, drugs, or other care for fertility studies, artificial insemination, in-vitro fertilization, embryo transport, gamete intra-fallopian transfer, gamete/zygote embryo transfer, donor semen or eggs, gamete transfer, HLA (human leukocyte antigen) typing, hormone pulsating infusions, reversal of elective sterilization procedures, sperm banking, preimplantation genetic testing or other assistive reproductive services.

MATERNITY CARE
Coverage is provided for treatment of an Inpatient and Outpatient for prenatal visits, including one (1) routine ultrasound per pregnancy, delivery, and postpartum care provided to the Member, Covered Spouse or Dependent children. Coverage is provided for newborn services furnished to the child(ren) of the Member or covered spouse.

Notification of birth of a newly born child and payment of the required premium or fees must be furnished to BFH within thirty-one (31) days after the date of birth in order to have the coverage continue beyond that thirty-one (31) day period.

The Plan will pay routine nursery charges and routine charges for a well baby born in a Hospital for the length of the mother's stay. Newborn charges are Covered Services only when the infant is an eligible Dependent of the Member as defined in the eligibility section. Coverage includes the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities, inherited metabolic diseases, including complications thereof, and in-Hospital hearing screening of a newborn.

The Plan will pay:

A. For Inpatient care for a mother and her newly-born child for a minimum of forty-eight (48) hours after vaginal delivery and a minimum of ninety-six (96) hours after delivery by Caesarean section; or
B. For a shorter length of stay, with the consent of the mother, if the Physician determines that the mother and the newborn meet medical stability criteria and the Plan authorizes an initial postpartum home health care visit which includes the collection of an adequate sample for hereditary and metabolic newborn screening.

SPECIAL DELIVERY℠ MATERNITY PROGRAM

Special Delivery℠ Maternity Program – The Plan offers this program for expectant mothers to provide support and education during their pregnancy. Members are provided with health and pregnancy education materials including the comprehensive guide, Your Pregnancy & Birth, developed by the American College of Obstetricians and Gynecologists. Members enrolled in the program have access to a registered nurse Case Manager who provides ongoing communication and resources specific to their pregnancy. In addition, when there is a high-risk pregnancy, the Plan follows the Member's progress through Our case management program. A dedicated RN Case Manager will assist with the Member's care coordination. Members may also enroll online at www.bgfh.com by clicking on "Maternity Program" and then "Special Delivery Prenatal Questionnaire" under the Member's tab.

MEDICAL CASE MANAGEMENT

The Plan's Case Management program may be available to Members who have chronic, traumatic, progressive, or life-threatening medical conditions. A registered nurse will assist with planning and coordinating the options and services required to meet Members' healthcare needs. Examples of those who may be appropriate for Case Management services include Members who have had a prolonged or traumatic hospitalization; require continued care due to a newly diagnosed condition; require prolonged home care after discharge from the Hospital; or require complex education to manage their disease process.

MEDICAL SUPPLIES

Medical supplies are supplies used in the medical care of an illness or injury. These supplies are designed only to serve a medical purpose and do not meet the definition of DME. Medical supplies used in the direct administration of a Covered Service by a Provider are covered. Supplies provided for use by a Covered Person are limited to supplies for ostomy care, tracheotomy care, wound care, supplies for urinary catheterization, and diabetic care. Common household items are not considered medical supplies.

NEWBORN BENEFITS

Benefits for newborns are subject to the Eligibility and effective date of Coverage section of this Certificate, as well as all terms and provisions of the Plan.

Covered expenses / Covered Services incurred during a newborn child's initial inpatient Hospital confinement include Hospital expenses for room and board and miscellaneous services; Provider's expenses for circumcision; and Provider's expenses for routine examination before release from the Hospital.

NURSEFIRST℠

NurseFirst℠ is a health triage phone service provided by the Plan. Covered Persons have access to a registered nurse twenty-four (24) hours a day, seven (7) days a week at (800) 391-6861. NurseFirst is available for Members when they need answers to health questions or wish to become more knowledgeable about a particular condition.

NUTRITIONAL COUNSELING

BFH will cover Medical Nutritional Counseling provided by physicians, mid-level Providers, or registered dieticians or nutritionists for the medical management of members diagnosed with medical conditions that may be exacerbated by nutritional factors and/or conditions that may be negatively impacted by poor nutritional status such as chronic renal failure, gestational diabetes (pregnancy-induced diabetes), diabetes mellitus, and those with impaired fasting glucose (often referred to as "pre-diabetes"), and eating disorders such as anorexia nervosa and bulimia.

ORTHOTIC DEVICES

Coverage for the purchase, fitting, necessary adjustments, repair and replacements for Medically Necessary orthotics which support, align, correct or improve the function of a malfunctioning, moveable external body part. Benefits are available for the most cost-effective orthotic if more than one orthotic is available and can meet the functional needs. The orthotic must be ordered and/or provided by the direction of a Physician.

PRESCRIPTION DRUGS

Please refer to Your Schedule of Benefits or contact Customer Service to determine if You have prescription drug coverage.

If Your plan has prescription drug coverage, You must use a participating pharmacy (except in an urgent or emergent situation) and Your pharmacist must transmit the claim via computer to the Plan's Pharmacy Benefit Manager (PBM). If You are at the pharmacy and You do not have Your BFH ID card, please instruct the pharmacist to contact BFH's Pharmacy Services Department at (877) 205-6308 or (859) 335-3755. Prescriptions purchased at participating pharmacies that have not been submitted online by the pharmacist will not be eligible for reimbursement.

Plans with Prescription Drug coverage provide benefits for both generic and brand name prescription medications. A generic medication is called by its chemical name; a manufacturer assigns a brand name. Brand medications may have generic equivalents. The price of the generic medication is usually lower than that of a brand name medication. Both generic and brand name products have the same *active* ingredients. Overall, the generic medication is just as safe and effective as the brand name medication.

Dispense as Written (DAW) 1 and 2 Penalty

Applicable state law requires that when there is a generic medication available for a branded medication that the pharmacist dispense the generic product unless otherwise stated by the prescriber to dispense as written or it is requested by the patient. If a prescriber or a member specifically requests a brand name medication when a generic medication is available, the member will be subject to their applicable co-payment and will be responsible for any difference in price between the generic medication and the brand name medication.

Inborn Errors of Metabolism or Genetic Conditions

Except for the treatment of inborn errors of metabolism or genetic conditions, prescription drug coverage is limited to injectable insulin, including syringes and diabetic supplies, contraceptives for which a prescription is required, and drugs

that under Federal law may only be dispensed by written prescription, which are approved for general use for treatment of a given condition by the Food and Drug Administration, and which are adopted by the Plan. The drugs must be dispensed by a licensed Pharmacy Provider during the period a Covered Person is an Outpatient and is eligible to receive benefits under the Plan.

Mail Order Services
The Plan offers prescription mail order services for maintenance medications. The list of maintenance medications is updated by the Plan. In most benefit plans, a three-month supply of each prescription medication is the minimum that can be ordered via mail order. The Plan will only provide coverage for a three (3) month supply of maintenance medications that are expected to be used during the Plan Year. The three (3) month supply will be modified so that coverage beyond twelve (12) months designated in the benefit is not provided. In accordance with the FDA guidelines, the quantity dispensed and/or timeframe of use of certain covered medications may be limited.

New Prescription Drugs
New prescription drugs to the market which contain a new manner of action or new delivery system will not be considered for coverage until six (6) months after the product is widely available.

Outside of Service Area
If You are outside the Service Area and You need to have a prescription filled, You may take Your prescription and Your ID card to any participating chain pharmacy. If the pharmacy encounters difficulty in processing the claim, please instruct the pharmacist to contact BFH's Pharmacy Services Department at 877-205-6308 during normal business hours (Monday – Friday, between 8 AM and 6 PM Eastern Time excluding holidays) or Express Scripts® PBM Call Center at 877-213-7465 after business hours, on weekends and on holidays.

Prescription Reimbursement of Eligible Out-of-Pocket Expenses
If You pay out-of-pocket for a prescription at a participating pharmacy, You may return to the pharmacy within sixty (60) days, have the claim reprocessed electronically and be reimbursed for the eligible out-of-pocket expense. If You are reimbursed by the Plan for an eligible out-of-pocket prescription expense, You will be paid based on the Plan's contracted pharmacy rates, minus Your applicable prescription cost share. Requests for out-of-pocket prescription reimbursement received more than six (6) months after the prescription was filled will not be eligible for reimbursement.

Quantity Limits and Timeframes of Usage
In accordance with the Food and Drug Administration (FDA) guidelines, the quantity dispensed and/or timeframe of use of certain covered medications may be limited. FDA approved maximum doses established for safety will determine quantity limits. For some medications, a one (1) month supply does not equal thirty (30) units. Benefits for covered prescription medications are limited to quantities that can reasonably be consumed or used within one (1) month, or as otherwise authorized under the Plan. Limits are based on clinical considerations including patient safety and appropriate use. Sample listing of these medications include narcotic analgesics, sedative/hypnotics, migraine medications and second-line antibiotics.

Specialty Drugs and Injectables
Specialty drugs and Injectables may only be obtained through Curascript Specialty Pharmacy Services. PA is required for certain specialty drugs including those delivered in the physician office, clinic, or home setting. Please refer to the Medical Pre-Certification List as reference to these medications billed under the Medical Benefit. Self-injectable drugs are only covered under the member's Prescription Drug Benefit.

Step-Therapy
In order for some medications to be covered, step-therapy may be required. Step therapy is an electronic PA process that takes place at the time the pharmacist files the claim. For medications that are considered "second-line" agents, the claims system will look at the member's BFH claims history and if a claim(s) for the required "first-line" medication(s) is found, the system will approve the claim. If "first-line" medications are not found, the system will not approve the claim and will send a message back to the pharmacy advising that the step-therapy protocol has not been met. At that time, the pharmacy may contact Your physician and request that they contact the Plan for PA.

PROSTHETIC APPLIANCES
Coverage for the purchase, fitting, necessary adjustments, repair and replacements for Medically Necessary external prosthetics which artificially substitute or replace a part of the body. Coverage is limited to the replacement of arms, legs, feet and hands; artificial eyes, ears and noses; and breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998, including mastectomy bras and lymphedema stockings for the arm. Benefits are available for the most cost-effective prosthetic if more than one prosthetic is available and can meet the functional needs. The prosthetic must be ordered and/or provided by the direction of a Physician.

RECONSTRUCTIVE SURGERY
Services, supplies or care incurred for reconstructive surgery: 1) when such surgery is incidental to or follows surgery resulting from injury or illness of the involved part; 2) because of congenital disease or anomaly of a Covered Person which has resulted in a functional defect (difficulty in activities of daily living); or 3) all stages of breast reconstruction surgery and correction of breast size disproportion or dyssymetry following a mastectomy that resulted from breast cancer.

SKILLED NURSING FACILITY SERVICES
Room and board in semi-private accommodations in an approved Nursing Facility for skilled nursing or rehabilitation care. The admission to the Nursing Facility must either follow Hospital confinement and diagnosis necessitating the Nursing Facility or be in lieu of Hospital confinement.

TEMPOROMANDIBULAR OR CRANIOMANDIBULAR JOINT DISORDER AND CRANIOMANDIBULAR JAW DISORDER
Covered Services incurred for surgical treatment of temporomandibular joint (TMJ), craniomandibular joint (CMJ), or craniomandibular jaw (orthognathic) disorder. TMJ or CMJ disorder is a jaw/joint disorder that may cause pain, swelling, clicking and difficulties in opening and closing the mouth and complications include arthritis,

dislocation and bite problems of the jaw. Craniomandibular jaw (orthognathic) disorders involve documented skeletal disorders of the jaw. Procedures for the treatment of craniomandibular jaw maldevelopments that are not correctable with conventional orthodontic treatment yielding a stable and functional post-treatment occlusion without worsening the patient's aesthetic condition shall be covered surgical procedures.

Covered Services for non-surgical diagnosis and treatment of TMJ or CMJ dysfunction or disorder or craniomandibular jaw disorders are limited to:

1) diagnostic examination; 2) diagnostic x-rays; 3) injection of muscle relaxants; 4) therapeutic drug injections; 5) physical therapy; 6) diathermy therapy; 7) ultrasound therapy; 8) splint therapy; and 9) arthrocentesis and aspiration.

Benefits are not provided for anything not listed above, including: 1) any appliance or the adjustment of any appliance involving orthodontics; 2) any electronic diagnostic modalities; 3) occlusal analysis; and 4) muscle testing.

THERAPY SERVICES

Benefits are available for the short-term outpatient rehabilitative treatment of an **acute** condition, by manual or physical means, including:

A. Physical Therapy - The treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, biomechanical and neurophysiological principles, and devices to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of a body part.

B. Occupational Therapy - The treatment program of prescribed activities, emphasizing coordination and mastery, designed to assist a person to regain independence, particularly in the normal activities of daily living.

C. Speech Therapy - The treatment rendered to restore speech loss due to injury, stroke, or a congenital anomaly.

D. Cardiac Rehabilitation - To receive Phase II Outpatient Cardiac Rehabilitation, a Covered Person must have suffered an acute myocardial infarction (MI or heart attack) or a cardiac revascularization procedure (angioplasty, coronary artery bypass graft surgery (CABG), or stent placement) within the twelve (12) months preceding the initiation of the rehabilitation program. Phase III Cardiac Rehabilitation is not a Covered Benefit since these programs are considered educational in nature with an emphasis on continuing exercise programs and behavioral modification related to risk factors. To be eligible for Cardiac Rehabilitation as an Inpatient, a Covered Person must not be admitted to a Hospital solely for the purpose of receiving cardiac rehabilitation.

E. Chiropractic Therapy – Treatment focused on disorders of the musculoskeletal system and the nervous system, and the effects of these disorders on general health. Chiropractic care is used most often to treat neuromusculoskeletal complaints, such as back pain, neck pain, pain in the joints of the arms or legs and headaches. The most common therapeutic procedure performed is “spinal manipulation,” also called “chiropractic adjustment.” The purpose of manipulation is to restore joint mobility by manually applying a controlled force into joints that have become hypomobile – or restricted in their movement – as a result of a tissue injury.

Rehabilitation services must be performed by a licensed therapy Provider, under the direction of a Physician. Benefits are available only for rehabilitation services that are expected to result in significant physical improvement in a Covered Person's condition within two (2) months of the start of treatment.

TRANSPLANTS

Benefits for human organ or tissue transplants are limited to kidney, kidney/pancreas, certain bone marrow, heart, liver, lung, heart/lung, small bowel and pancreas transplants. Benefits are also available for cornea transplants and are covered as any other illness. The Plan does not provide benefits for a transplant or transplant related procedures that are not Medically Necessary or are Experimental or Investigational. Benefits are provided for autologous bone marrow transplants for breast cancer as required by law.

To be eligible to receive benefits, the Enrollee must use a Participating/Designated Facility and/or Provider approved by the Plan that is (are) qualified to perform the above transplant procedures and will comply with the Plan's medical utilization management provisions. No benefits will be paid for charges for the transplant if Prior Authorization for the procedure was not obtained before the pre-testing, evaluation and donor search.

A. Benefit Eligibility

When Physician's services are required for transplants from a living donor to a transplant recipient requiring surgical removal of a donated part, the following will determine the benefits to be provided, but only when the Physician customarily bills the recipient for such services.

1. When the transplant recipient and donor are both Enrollees under this Certificate, benefits will be provided for both under each individual's available coverage.
2. When only the transplant recipient is eligible under this Certificate, benefits will be provided for both to the extent that benefits to the donor are not provided under any other coverage. In such instances, donor utilization of benefits will be charged against the recipient's coverage.
3. When the transplant recipient is not eligible under this Certificate, and the donor is, the donor will receive his or her benefits under the Certificate for surgical and medical care necessary to the extent such benefits are not provided by any coverage available to the recipient for the organ or tissue transplant procedure. Benefits will not be provided to any noneligible transplant recipient.

B. Eligible Expenses

1. Eligible Expenses include charges incurred by the recipient for Covered Services that are directly related to or result from the completion of a covered transplant procedure, including all pre-operative and post-operative services.
2. Eligible Expenses also include charges that are directly related to the surgical, storage, and transportation costs incurred in the donation of an organ for a covered transplant procedure.
3. In order to pre-authorize the transplant procedure itself, the Plan must be given the opportunity to review the clinical results of the evaluation. Prior

Authorization will be based on written criteria and procedures established or adopted by the Plan.

C. Limitations within the Transplant Network

For each transplant episode Covered Services / Covered Charges will be limited to: No more than one listing with the United Network of Organ Sharing (UNOS).

D. Non-Eligible Expenses

1. No benefits will be paid unless the coverage is in effect on the date the covered procedure is performed.
2. No benefits will be paid for any expenses incurred by a living donor for transportation, meals or lodging.
3. In addition to the Exclusions applicable under this Certificate, benefits will not be provided for covered expenses:
   a. Related to the transplant of any non-human organ or tissue, or
   b. Which are repaid under any private or public research fund.
4. Denied charges for a covered procedure or non-covered expenses in connection with a covered procedure are not eligible for payment under any other part of this Certificate.
5. Any human organ or tissue transplant not specifically listed in this Certificate. However, the Plan may amend the Covered Transplant Procedure list to include additional diagnoses when published peer-reviewed studies establish that transplantation has a positive long-term outcome.

The Plan has a dedicated registered nurse Case Manager who specializes in transplant issues. The Transplant Case Manager not only helps Members understand what to expect at this important time, but also coordinates care between Members, Physicians and Hospital staff through all phases of an organ transplant.

VISION COVERAGE

Please refer to Your Schedule of Benefits or contact Customer Service to determine if vision and/or vision hardware is covered under Your Plan.

Coverage for vision examinations (refractions) up to one (1) exam every twelve (12) months if less than eighteen (18) years of age and up to one (1) exam every twenty-four (24) months for ages eighteen (18) and older.

VOLUNTARY STERILIZATION

Regardless of Medical Necessity, coverage is provided for outpatient procedures performed for the sole purpose of voluntary sterilization.

EXCLUSIONS

This section lists what is not covered. Members should read this section carefully to understand what benefits are not included in the Certificate.

The following section indicates items that are excluded from benefit consideration, and are not considered Covered Services. This information is provided as an aid to identify certain common items that may be misinterpreted as Covered Services, but is in no way a limitation upon, or a complete listing of, such items considered not to be Covered Services. The titles of each section are to facilitate location of the exclusions and should not be interpreted to limit the terms of the Exclusions.

ABORTION
Services, supplies and other care provided for elective abortions, as defined by applicable state statute.

ALCOHOL/CHEMICAL DEPENDENCY/SUBSTANCE ABUSE
Medications or other prescription drugs used by an Outpatient to maintain an addiction or dependency on drugs, alcohol, or chemicals. Services, supplies, or other care associated with the treatment of Substance Abuse whenever the Covered Person fails to comply with the Plan of treatment (such as detoxification, rehabilitation or care as an Outpatient) for which the services, supplies, or other care was rendered or a Claim was submitted. Medical detoxification is treated as any other illness.

ALLERGY TESTING
Benefits are not provided for certain allergy tests, such as but not limited to, skin titration (Rinkel Test), cytotoxicity testing (Bryan's Test), urine auto injection, provocative and neutralization testing for allergies, or for an assessment of IgG antibodies in food allergies.

ALTERNATIVE MEDICINE
Services, supplies, or other care for acupuncture, acupressure, or other alternative medicine.

ANESTHESIA BY HYPNOSIS
Anesthesia by hypnosis, anesthesia charges for services not covered by this Plan.

BEHAVIORAL HEALTH SERVICES
Services or supplies for Mental Health Conditions unless performed by a Physician or other Provider who is licensed or certified by the applicable state licensing or certifying authority. Services for Mental Health Conditions when provided for purposes of medical, educational, or occupational training and/or licensing. Psychological testing beyond that necessary to establish a diagnosis or beyond that approved by the Plan. In no event will the Plan cover more than the Inpatient or Outpatient Mental Health Benefits specified in Your Schedule of Benefits.

BEHAVIORAL TRAINING AND MODIFICATIONS
Services, supplies, or other care provided for conditions related to conduct disorders (except attention deficit disorders), pervasive developmental disorders (except Autism Spectrum Disorders), behavioral disorders, learning disabilities and disorders, personality disorders, or mental retardation. Services, supplies or other

care for non-chemical addictions such as gambling, sexual, spending, shopping and working addictions, codependency, or caffeine addiction. Residential treatment, milieu therapy, nicotine smoking cessation programs and/or products, marriage counseling, environmental change, biofeedback, neuromuscular re-education, hypnotherapy, sleep therapy, vocational rehabilitation, sensory integration, educational therapy and recreational therapy, except for such adjunct services as part of the Inpatient stay and required by the Joint Commission on Accreditation of Healthcare Organizations or the Commission on Accreditation of Rehabilitative Facilities.

BLOOD AND RELATED PRODUCTS
Charges for the cost of donated blood, blood plasma and blood derivatives.

CHELATION THERAPY
Chelation therapy except in the treatment of lead or other heavy metal poisoning.

CIVIL DISTURBANCE/CRIME
Services, supplies, or other care provided in treatment of injuries sustained or illnesses resulting from participation in a riot or civil disturbance, while committing or attempting to commit a criminal act, or while engaging in an illegal occupation. Services, supplies or other care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs. This exclusion does not apply to a covered person while incarcerated in a local penal institution or in the custody of a local law enforcement officer prior to conviction for a felony.

COORDINATION OF BENEFITS
Services, supplies or other care to the extent that benefits or reimbursement are available from or provided by any other group coverage, except that the Plan will coordinate the payment of benefits under this Plan with such other coverage or as permitted by applicable state law.

COSMETIC SERVICES
Services, supplies, or other care for cosmetic services, and/or complications arising directly from the cosmetic services. Cosmetic services are surgical procedures performed to improve a Covered Person's appearance or to correct a deformity without restoring physical function. The presence of a psychological condition does not make a cosmetic service Medically Necessary and will not entitle a Covered Person to coverage for cosmetic services. Examples of exclusions are removal of tattoos, port wine stains, scars, wrinkles, skin tags, or excess skin; plastic surgery; silicone injections or implants; electrolysis; wigs, including those used as cranial prostheses; treatment of male pattern baldness; revision of previous elective procedures; gynecomastia; keloids; pharmaceutical regimes; nutritional procedures or treatments; rhinoplasty; epikeratophakia surgery; skin abrasions which are performed as a treatment for acne.

COURT-ORDERED
Services, supplies, other care or treatment when such order is the result of, or arises out of a conduct by the Covered Person which is or would be criminal activity under state or Federal law.

CUSTODIAL CARE
Services, supplies, or other care rendered by or in rest homes, health resorts, homes for the aged, places primarily for domiciliary or Custodial Care, and self-help training or other forms of non-medical self-care. Examples of Custodial Care include help in walking or getting in or out of bed, personal care such as bathing, dressing, eating, or preparing special diets, or taking medication.

DENTAL SERVICES
Benefits are not provided for dental services, supplies, treatments other care or procedures, regardless of origin or cause, except as otherwise specified in this Certificate, including Preventive Services, diagnosis, and treatment involving tooth structures, extractions, restoration, replacement of teeth, gingival tissues, alveolar processes, dental x-rays (other than for an accidental injury), procedures of dental origin, odontogenic cysts/tumors, or any orthodontic, or periodontic treatment regardless of Medical Necessity. Coverage is not provided for the treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly. Hospital services may be covered only when such services are prior authorized as Medically Necessary to safeguard the health of the Covered Person from the effects or side effects of a dental procedure due to a specific non-dental organic impairment. Services, supplies, treatments, or other care for maxillary and/or mandibular augmentation/implant procedures to facilitate the use of full or partial dental prostheses, fixed or removable are not covered.

Dental appliances other than those required in treatment of Temporomandibular Joint Disorder (TMJ) or Craniomandibular Jaw Disorder (CMJ) as otherwise specified in this Certificate are excluded.

Dental implants are not covered for any reason.

DISPOSABLE SUPPLIES
Benefits are not provided for disposable supplies to an Outpatient such as over the counter products such as, ace bandages, support hosiery, pressure garments, elastic stockings and band-aids.

DURABLE MEDICAL EQUIPMENT, PROSTHETIC APPLIANCES, ORTHOTIC DEVICES
Any DME, prosthesis, or orthotic device having convenience or luxury features which are not Medically Necessary, except that benefits for the cost of any standard equipment or device used in the treatment of disease, illness, or injury will be provided toward the cost of any deluxe equipment, prosthetic or device selected. Penile implants; athletic devices; purchase or rental of escalators or elevators; spas, saunas or swimming pools; professional medical equipment such as blood pressure kits; modifications to Your home or place of business, such as ramps, air conditioners, seat lift chairs, or supplies or attachments for any of these items are excluded. Benefits are also excluded for the repair, maintenance and/or replacement of DME, except as otherwise provided. No coverage will be considered for replacement of DME that is lost or stolen. No coverage for replacement or repair will be considered if equipment is broken by abuse or lack of maintenance. Adjustments made to vehicles, air purifiers, humidifiers, dehumidifiers, stair

gliders, emergency alert equipment, handrails, heat appliances, waterbeds, whirlpool baths, exercise and massage equipment are not covered.

EDUCATION
Services, supplies, or other care for educational or training procedures used in connection with speech, hearing, or vision therapy and/or services.

EFFECTIVE DATES
Except as otherwise required by law, services, supplies or other care, including those related to a hospital confinement and/or Total Disability rendered prior to the Effective Date of this Plan, , prior to the Covered Person's Effective Date, after the termination date of this Plan, or after the Covered Person's termination date are not covered.

EMERGENCY ROOM
Benefits are not provided for the use of an emergency room except for treatment of emergency medical conditions, screening and stabilization.

EXPERIMENTAL/INVESTIGATIONAL SERVICES
Services, supplies, or other care, which are Experimental or Investigational in nature. Please review the definition of Experimental or Investigational.

FAMILY MEMBER PROVIDER
Services, supplies, or other care rendered by a Provider who is a Member of the Covered Person's immediate family unless such services are provided in an emergency setting or in an isolated setting where there is no other qualified Physician available. Immediate family includes You, Your spouse, child, brother, sister, and parent or in-law of You or Your spouse.

FOOT RELATED SERVICES
Services or supplies for routine foot care or other care used (except capsular or bone surgery), in treatment of superficial lesions of the feet such as corns, hyperkeratosis, bunions, tarsalgia, metatarsalgia, calluses, nails of the feet (except mycotic infections or surgery for ingrown nails), flat feet, fallen arches, weak feet, or similar conditions, or the provision of arch supports, shoe inserts, foot orthotics, or orthopedic shoes, unless Medically Necessary for complications of diabetes.

GOVERNMENTAL HEALTH PLANS
Services, supplies, or other care to the extent that benefits are available under any governmental health Plan (including military service-related expenses in Veterans Administration Hospitals, but excluding Medicaid), except that this Plan will coordinate the payment of benefits under this Plan with such other governmental health Plans as permissible under existing laws and regulations.

HEARING RELATED SERVICES
Routine hearing tests or screenings other than the screening of a newborn in the Hospital. Audiograms and audiometric services, unless related to the diagnosis or management of a specific illness or traumatic injury. Hearing aids, except as otherwise provided.

HEART RELATED SERVICES
Services, supplies, or other care provided to an Inpatient solely for cardiac rehabilitation. Services, supplies, or other care provided for non-human, artificial, or mechanical hearts or ventricular and/or atrial assist devices used as a heart replacement (when not otherwise provided in conjunction with a human organ transplant) and supportive services or devices in connection with such care. This exclusion includes services for implantation, removal and complications.

HOME BIRTHS
Professional services for maternity delivery in a home setting or location other than a licensed hospital or birthing center.

HOME HEALTH CARE
Food, housing, home delivered meals and homemaker services (such as housekeeping, laundry, shopping and errands). Teaching household routine to Members of the Covered Person's family; supervision of a Covered Person's children; and other similar functions. Benefits are not provided for home health care education beyond the normal and customary period for learning. Supportive environmental materials, including hand rails, ramps, telephones, air conditioners and similar items. Services or supplies provided by the family of the Covered Person or volunteer Ambulance associations. Visiting teachers, friendly visitors, vocational guidance, and other counselors. Services related to diversional and social activities. Services for which there is no cost to the Member.

HOSPICE
Services, supplies, or other care except as covered by Medicare's Hospice benefit.

INFERTILITY
Services, supplies, drugs, or other care for fertility studies, artificial insemination, in-vitro fertilization, surrogate pregnancies, embryo transport, gamete intra-fallopian transfer, gamete/zygote embryo transfer, donor semen or eggs, gamete transfer, HLA (human leukocyte antigen) typing, hormone pulsating infusions, animal egg penetration testing, reversal of elective sterilization procedures, sperm banking, preimplantation genetic testing or other assistive reproductive services. **Please refer to Your Schedule of Benefits or contact Customer Service to determine if infertility is covered under Your Plan.**

LIPECTOMY
Services, supplies, and other care related to suction assisted lipectomy or diastasis recti repair, including instances when diastasis recti is associated with an umbilical or ventral hernia.

MAINTENANCE CARE
Services and/or supplies furnished mainly to maintain, rather than improve, a level of physical or mental function; or to provide a protected environment that can worsen the Covered Person's physical or mental condition.

MEDICARE
For Covered Persons who are covered by Medicare, to the extent that Medicare is the primary payer.

NETWORK RESTRICTIONS
Services, supplies, or other care provided that do not meet the Plan's Delivery System Rules.

NON-COVERED SERVICES
Services, supplies, or other care not specifically provided for in this Certificate. Eligible Expenses exceeding any maximum benefit under the Plan. Complications of a non-Covered Service.

NON-MEDICAL SERVICES
Services, supplies, or other care for personal hygiene, environmental control, convenience items (such as air conditioners, humidifiers, or physical fitness equipment), or personal comfort and convenience items (such as daily television rental, telephone services, cots or visitors' meals). Charges for: 1) telephone consultations, 2) failure to keep a scheduled visit, 3) completion of a Claim form, or 4) providing requested information to the Plan. Services or supplies provided for self-help training or other form of non-medical self-care. Purchase or rental of supplies of common household use such as exercise cycles, air purifiers, central or unit air conditioners, water purifiers, pillows or mattresses or waterbeds, treadmill or special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program. Services or supplies at a health spa or similar facility, including massage therapy.

NURSING FACILITIES
Services, supplies or other care in a Nursing Facility not requiring daily planned medical and skilled professional nursing care and supervision for a disease, illness, or injury.

NUTRITIONAL SERVICES
Food, food supplements (except special formulas Medically Necessary for the treatment of certain inborn errors of metabolism or genetic conditions), minerals, vitamins, or drugs which could be purchased without a written prescription, or are not FDA approved for treatment of a specified category of medical conditions, or are not Medically Necessary, or are considered to be Experimental or Investigative.

OBESITY
Weight reduction programs, treatment for obesity, including surgery, and any surgery for the removal of excess fat or skin following weight loss due to obesity, surgery, or pregnancy, regardless of Medical Necessity, or services at a health spa or similar facility. Services, supplies, or other care for gastric bypass procedures, gastric bubble/gastric balloon procedures, stomach stapling, wiring of the jaw, liposuction, and jejunal bypasses. Dietary supplements, diet pills, and appetite suppressants.

OBLIGATION TO PAY SERVICES
Services, supplies, or other care for which the Covered Person has no legal obligation to pay in the absence of this or similar coverage, or for which no charge has been made.

OUTSIDE UNITED STATES
Non-emergency treatment provided outside the United States.

PERSONAL INJURY PROTECTION
Sickness or bodily injury for which medical payments/personal injury protection (PIP) coverage exists under any automobile, homeowner, marine, aviation, premise, or any other similar coverage, whether such coverage is in effect on a primary, secondary, or excess basis. This exclusion applies up to the available limit under the other coverage regardless of whether a claim is filed with the medical payments/PIP carrier. Whether medical payment or expense coverage is payable under another coverage is to be determined as if the coverages under this Plan did not exist.

Any covered expenses to the extent of any amount received from others for the bodily injuries or losses which necessitate such benefits. "Amounts received from others" specifically includes, without limitation, liability insurance, worker's compensation, uninsured motorists, underinsured motorists, "no-fault" and automobile med-pay payments.

PRE-EXISTING CONDITION
Services, supplies, or other expenses incurred for a physical or mental condition, regardless of its cause, for which medical advice, diagnosis, care, or treatment was recommended or received within the six (6) month period ending on the Covered Person's Enrollment Date. Such exclusion of coverage for a Pre-Existing Condition may not exceed a period of twelve (12) months following the Enrollment Date. The Pre-Existing Condition exclusion does not apply to: 1) pregnancy, 2) genetic information in the absence of diagnosis, 3) domestic violence, or 4) Enrollees under the age of nineteen (19). If You have any questions regarding a Pre-Existing Condition, please contact BFH's Customer Service Department at (800) 787-2680 or (859) 269-4475.

PRESCRIPTION DRUGS
Please refer to Your Schedule of Benefits or contact Customer Service to determine if You have prescription drug coverage.
Drugs, except insulin, which could be purchased without a written prescription, or are not FDA approved for treatment for a specified category of medical conditions, unless such use is consistent with standard medical practice and has been demonstrated as effective in published peer review medical literature as leading to improvement in health outcomes, or not included within the Plan's formulary, if any. Replacement of lost, stolen, misplaced, damaged, or spilled medication is also excluded. Compounded medications that are prepared by a pharmacist and are not FDA approved in their final form will not be covered at any benefit level. New drugs to the market which contain a new manner of action or new delivery system will not be considered for coverage until six (6) months after the product is widely available.

SEX TRANSFORMATION /SEXUAL DYSFUNCTION
Services, supplies, drugs or other care related to sex transformation, sexual dysfunction or inadequacies.

STERILIZATION REVERSAL
No coverage is provided for the reversal or any attempted reversal of a previously performed sterilization.

THIRD-PARTY REQUIRED SERVICES
Any service, supply, treatment, immunizations, or care when recommended and/or required by a third-party entity for the purpose of sports, school (except approved well visits), camp, employment, licensing requirements, travel, insurance, marriage, adoption, services conducted for medical research, examinations required by a court or legal proceedings are not covered.

TRAVEL/TRANSPORTATION

Travel or transportation expenses (except Ambulance), even though prescribed by a Physician. Air Ambulance is excluded, except if Plan determines an air Ambulance is the only medically appropriate means of transportation to the nearest appropriate facility.

VISION SERVICES
Please refer to Your Schedule of Benefits or contact Customer Service to determine if You have vision coverage.
For Plans without Vision Coverage Eyeglasses, including contact lenses, whether or not prescribed (except for implanted cataract lenses following surgery for cataracts or a similar medical condition). Treatment for the correction of refractive error; examples include radial keratotomy, keratomileusis or lasik eye surgery.
For Plans with Vision Coverage but without hardware benefits Eyeglasses, including contact lenses, whether or not prescribed (except for implanted cataract lenses following surgery for cataracts or a similar medical condition). Treatment for the correction of refractive error; examples include radial keratotomy, keratomileusis or lasik eye surgery.

WAR INJURIES
Services, supplies, or other care for diseases or injuries sustained as a result of military service, war (declared or undeclared), or any act of war.

WORKERS' COMPENSATION
Services, supplies, or other care for any condition, disease, ailment, or injury arising out of and in the course of employment if the Covered Person is engaged in any employment or occupation that is required under any worker’s compensation act or similar law to provide such coverage for employees. This exclusion applies if the Covered Person receives the benefits, in whole or in part. This exclusion also applies regardless of whether the Covered Person claims the benefits or compensation. If there is a final determination by the board of worker’s claims that the aforesaid injury is not work related, then this exclusion will not apply.

GENERAL PROVISIONS

IDENTIFICATION CARD

ID Cards are issued to Covered Persons for identification purposes only and must be presented to the Providers of care when Covered Services are sought. Possession of an ID card does not guarantee a right of benefits under this Certificate. To be entitled to benefits, the holder of the ID card must be the Covered Person on whose behalf all applicable Premiums have actually been paid. Persons receiving services or other benefits to which they are not entitled will be charged for the services. The ID card is the property of the Plan and its return may be requested at any time. Loss or theft of an ID card should be reported to the Plan immediately.

If any Covered Person misuses or permits the use of his or her ID card by any other person or otherwise attempts to defraud the Plan, the card may be confiscated by the Plan and all rights of the Covered Person under this Certificate may cease immediately or retroactively to the Covered Person's effective date of coverage, at the sole discretion of the Plan.

REFUSAL TO ACCEPT TREATMENT

A Member may, for personal reasons, refuse to accept or adhere to a treatment or procedure recommended by a Physician. The Physician may regard such refusal to accept the Physician's recommendation as incompatible with the continuance of the patient-physician relationship and as obstructing the provision of proper medical care. If a Member refuses to accept such a recommended treatment or procedure, and Physician believes that no professionally acceptable alternative exists, such Member shall be so advised in writing and informed of the right to seek review of the matter under the Appeals Procedure. If the Member still refuses to accept the recommended treatment or procedure, then neither the Plan nor Physician shall have further responsibility for the condition under treatment or to provide care for complications arising from such refusal.

MEDICAL CHILD SUPPORT ORDERS

An individual who is a child of a Covered Person shall be enrolled for coverage under the Plan in accordance with the direction of a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSN).

A QMCSO is a state court order or judgment, including approval of a settlement agreement that: 1) provides for support of a Covered Person's child; 2) provides for health care coverage for that child; 3) is made under state domestic relations law (including a community property law); 4) relates to benefits under the Plan; and 5) is "qualified" in that it meets the technical requirements of ERISA or applicable state law. QMCSO also means a state court order or judgment that enforces a state Medicaid law regarding medical child support required by Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993).

An NMSN is a notice issued by an appropriate agency of a state or local government that is similar to a QMCSO that requires coverage under the Plan for the dependent child of a non-custodial parent who is (or will become) a Covered Person by a domestic relations order that provides for health care coverage.

Procedures for determining the qualified status of medical child support orders are available at no cost upon request from Your Employer.

CLAIMS PROVISIONS

Participating Providers are responsible for submitting claims directly to the Plan within the Provider's applicable timeframe for submitting claims for Covered Services rendered on a Covered Person's behalf. The Member may submit to the Plan written notice of a claim, which should include the Member's name, the patient's name, and the Group number directly to the Plan within twelve (12) months from the date of service. The Plan is authorized to make all payments within thirty (30) days of receipt for benefits directly to Participating Providers for Covered Services rendered, after the Covered Person has satisfied any required Deductibles, Coinsurance and/or Copayments. The Plan will make all payments within thirty (30) days of receipt for benefits directly to the Covered Person for Covered Services rendered by a Non-Participating Provider. A Covered Person may not assign Benefits under the Plan to a Non-Participating Provider without Our consent; however, We may choose to pay a Non-Participating Provider directly for services rendered to a Covered Person, upon Our discretion.

Information received from Covered Person's medical records and information received from Providers will be kept strictly confidential to the extent required by law. As a condition of the Plan's agreement to provide benefits under this Certificate, the Covered Person consents and authorizes the release by any Provider of all medical records or other medical information involving any condition for which a claim is presented to be furnished to the Plan at its request. The Covered Person waives any and all privileges regarding such information. The processing of claims for benefits may be suspended until sufficient information can be obtained to determine the Plan's liability for coverage.

Whenever payment of benefits has been made by Us in error, We have the right to recover such mistaken payment from the member or, if applicable, the Provider. We reserve the right to deduct or offset any payments made in error from any pending or future claim for benefits.

You do not have the right to bring any legal proceeding or action against the Plan without first completing the complaint procedure. If You do not bring such legal proceeding or action against the Plan within one (1) year of the date the Plan notified You of its final decision, You forfeit Your rights to bring any action against the Plan.

COORDINATION OF BENEFITS

All benefits provided under this Certificate are subject to this coordination of benefits provision, which is applicable for the term of this Certificate. If this Certificate is primarily responsible for claims of Covered Services rendered to a Covered Person in accordance with this provision, the benefits of any other health plans under which coverage is available to the Covered Person will be ignored for purposes of determining the benefits determined under this Certificate. If this Certificate is secondarily responsible on claims for Covered Services rendered to a Covered Person in accordance with this provision, the benefits provided for Covered Services under this Certificate will be reduced to the extent necessary so that the sum of the reduced benefits under this Certificate and the benefits determined by the other health plan(s) do not exceed the total allowed amount for

such Covered Services. "Allowable Expense" means a health care service or expense including deductibles, coinsurance or copayments, which is covered in full or in part by any of the plans covering the person.

As used in this provision, the term "health plan" means any coverage providing benefits for Covered Services through: 1) individual, group, or blanket insurance coverage; 2) group practice, individual practice, and other prepayment coverage; 3) coverage under labor-management trusted plans or employee benefit organization plans; and 4) coverage under governmental programs, except Medicaid. The term "health plan" will be applied separately with respect to each coverage for benefits or services and separately with respect to that portion of any coverage which reserves the right to take the benefits or services of other health plans into consideration in determining its benefits and that portion which does not. When a "health plan" provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both a Covered Service and a benefit paid. The term "benefit reserve" is defined as the savings recorded by a plan for claims paid for a covered person as a secondary plan rather than a primary plan.

A secondary plan shall reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than one hundred percent (100%) of total allowable expenses. "Claim determination period" means a period of at least twelve (12) consecutive months, over which allowable expenses shall be compared with total benefits payable in the absence of coordination of benefits, to determine whether overinsurance exists and how much each plan will pay or provide.

A. The secondary plan shall calculate its savings by subtracting the amount that it paid as a secondary plan from the amount it would have paid had it been primary and any savings shall be:
    1. Recorded as a benefit reserve for the covered person; and
    2. Used by the secondary plan to pay any allowable expenses, not otherwise paid, that are incurred by the Covered Person during the claim determination period.
B. By the end of the claim determination period, the secondary plan shall:
    1. Determine whether a benefit reserve has been recorded for the Covered Person;
    2. Determine whether there are any unpaid allowable expenses for that claims determination period; and
    3. Pay any unpaid allowable expenses for that claim determination period.
C. The secondary plan shall use the Covered Person's recorded benefit reserve, if any, to pay up to one hundred percent (100%) of total allowable expenses incurred during the claim determination period, at the end of which:
    1. The benefit reserve shall return to zero (0); and
    2. A new benefit reserve shall be created for each new claim determination period.

The benefits of the secondary plan shall be reduced when the sum of the benefits payable under the secondary plan, in the absence of a coordination of benefits provision, and the benefits that would be payable under the other plans, in the

absence of this coordination of benefits provision, whether or not a claim is made, exceeds the allowable expenses in a claim determination period, with a reduction of benefits as follows:

A. The benefits of the secondary plan shall be reduced so that they and the benefits payable under the other plans do not total more than the allowable expenses; and

B. Each benefit is reduced in proportion and charged against any applicable benefit limit of the plan.

In processing a claim for services rendered to a Covered Person covered under two (2) or more health plans, including this Certificate, the "primary-secondary" payment rule determines the provision of benefits. The first of the following requirements that describes which plan pays its benefits as primary before another plan is the requirement to use:

A. Nondependent or dependent. The plan that covers the person other than as a dependent is primary and the plan that covers the person as a dependent is secondary unless the person is a Medicare beneficiary, in which case the order of benefits is determined in accordance with 42 USC 1395.

B. A child, including a newborn, covered under more than one (1) plan.
   1. The primary plan is the plan of the parent whose birthday is earlier in the year if:
      a. The parents are married;
      b. The parents are not separated (whether or not they ever have been married); or
      c. A court decree awards joint custody without specifying that one (1) parent has the responsibility to provide health care coverage.
   2. If both parents have the same birthday, the plan that has covered either of the parents longer is primary.
   3. If a court decree states that one (1) parent is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's spouse does, the spouse's plan is primary.
   4. If the parents are not married or are separated or divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and the parents' spouses (if any) is:
      a. The plan of the custodial parent;
      b. The plan of the spouse of the custodial parent;
      c. The plan of the noncustodial parent; and then
      d. The plan of the spouse of the noncustodial parent.

C. Active or inactive employee. The plan that covers a person as an employee who is neither laid off nor retired, or as that employee's dependent, is primary.

D. Continuation coverage. If a person whose coverage is provided under a right of continuation pursuant to federal or state law is also covered under another plan, the plan covering the person as an employee, member, subscriber or

retiree, or as that person's dependent, is primary and the continuation coverage is secondary.

E. Longer or shorter length of coverage. If the preceding requirements do not determine the order of benefits, the plan that covered the person for the longer period of time is primary:
   1. To determine the length of time a person has been covered under a plan, two (2) plans shall be treated as one (1) if the covered person was eligible under the second within twenty-four (24) hours after the first ended;
   2. Changes during a coverage period that do not constitute the start of a new plan include:
      a. A change in scope of a plan's benefits;
      b. A change in the entity that pays, provides or administers the plan's benefits; or
      c. A change from one (1) type of plan to another.
   3. The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.
F. If none of the preceding requirements determines the primary plan, the allowable expenses shall be shared equally between the plans.
G. If another health plan, other than this Certificate, contains an order of benefit determination rule, which uses gender as the determinant factor, that plan shall always be primary.

If another health plan, other than this Certificate, does not contain coordination of benefits provisions establishing order of benefit determination rules as used in this Certificate, the benefits under that other health plan will be determined before the benefits under this Certificate.

In order to determine the application and administration of the terms of this coordination of benefits provision, the Plan may, without the consent or notice to any person, release to or obtain from any Provider of Covered Services, employer, insurance company, or any other organization or person any information the Plan considers necessary to implement this provision. Furthermore, any individual claiming benefits under this Certificate must also provide the Plan with any information necessary to administer this provision.

Whenever any payment for Covered Services has been made by the Plan in an amount that exceeds the maximum benefits available for such services under this provision, the Plan reserves the right to recover such overpayments from the Covered Person, the Provider of Covered Services, another health plan, or an insurance company. In the alternative, the Plan further reserves the right to deduct from any pending claim for services rendered under this Certificate any amounts the Covered Person owes the Plan.

Whenever any payment has been made by another health plan that should have been provided under this Certificate as a result of coordination of benefits, the Plan reserves the right, in its sole discretion, to reimburse such other health plan for the necessary amount(s) in order to satisfy the intent of this provision. Any amounts

paid will be considered to be benefits paid under this Certificate, and, to the extent of such reimbursement, the Plan will be fully discharged from liability under this Certificate.

Right of Recovery
If the amount of the payments made by the Plan is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the Member. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

If the Plan pays benefits on Your behalf under the Certificate of Coverage for expenses incurred due to an automobile accident, then the Plan retains the right to seek repayment of the cost of such benefits. The Plan has the right in this situation to pursue available recovery from any medical payments coverage or personal injury protection/no-fault coverage existing under any automobile policy. The Plan also retains the right to seek recovery as outlined in the Subrogation section of the Certificate of Coverage.

MEDICARE
Any benefits covered under both this Certificate and Medicare will be paid pursuant to Medicare Secondary Payor legislation, regulations, and Centers for Medicare and Medicaid Services guidelines, subject to federal court decisions. In the event of a conflict between federal law, state law and Certificate provisions, Federal law will prevail.

Except when federal law requires the Plan to be the primary payor, the benefits under this Certificate for Members age sixty-five (65) and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Part B where Members shall be reimbursed by or on behalf of the Members to the Plan, to the extent the Plan has made payment for such services.

Medicare benefits are determined as if the full amount that would have been payable under Medicare was actually paid under Medicare, even if:

A. The person is entitled but not enrolled for Medicare. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.

B. The person is enrolled in a Medicare+Choice (Medicare Part C) plan and receives non-covered services because the person did not follow all rules of that plan. Medicare benefits are determined as if the services were covered under Medicare Parts A and B.

C. The person receives services from a Provider who has elected to opt-out of Medicare. Medicare benefits are determined as if the services were covered under Medicare Parts A and B and the Provider had agreed to limit charges to the amount of charges allowed under Medicare rules.

D. The services are provided in any facility that is not eligible for Medicare reimbursements, including a Veterans Administration facility, facility of the Uniformed Services, or other facility of the federal government. Medicare

benefits are determined as if the services were provided by a facility that is eligible for reimbursement under Medicare.

E. The person is enrolled under a plan with a Medicare Medical Savings Account. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.

COORDINATION OF BENEFITS WITH MEDICARE

When an employer employs one hundred (100) or more persons, the benefits of the Plan will be payable first for a Covered Person who is under age sixty-five (65) and eligible for Medicare. The benefits of Medicare will be payable second.

MEDICARE PART A means the Social Security program that provides Hospital insurance benefits.

MEDICARE PART B means the Social Security program that provides medical insurance benefits.

For purposes of determining benefits payable for any Covered Person who is a retiree or the covered spouse of a retiree and who is eligible to enroll in Medicare Part B, but does not, the Plan assumes the amount payable under Medicare Part B to be the amount the Covered Person would have received if he or she enrolled for it. A Covered Person is considered to be eligible for Medicare on the earliest date coverage under Medicare could become effective for him or her.

OPTIONS

Federal Law allows the Plan's actively working covered employees age sixty-five (65) or older and their covered spouses who are eligible for Medicare to choose one of the following options:

OPTION 1 - The benefits of the Plan will be payable first and the benefits of Medicare will be payable second.

OPTION 2 - Medicare benefits only. The Covered Person and his or her dependents, if any, will not be covered by the Plan.

Each covered employee and each covered spouse will be provided with the choice to elect one of these options at least one month before the covered employee or the covered spouse becomes age sixty-five (65). All new covered employees and newly covered spouses age sixty-five (65) or older will also be offered these options. If Option 1 is chosen, its issue is subject to the same requirements as for a covered employee or dependent who is under age sixty-five (65).

Under Federal law, there are two categories of persons eligible for Medicare. The calculation and payments of benefits by the Plan differs for each category.

CATEGORY 1 Medicare Eligibles are actively working covered employees age 65 or older and their age 65 or older covered spouses, and age sixty-five (65) or older covered spouses of actively working covered employees who are under age sixty-five (65).

CATEGORY 2 Medicare Eligibles are any other covered persons entitled to Medicare, whether or not they enrolled for it. This category includes, but is not

limited to, retired covered employees and their spouses or covered dependents of a covered employee other than his or her spouse.

CALCULATION AND PAYMENT OF BENEFITS
For Covered Persons in Category 1, benefits are payable by the Plan without regard to any benefits payable by Medicare. Medicare will then determine its benefits.

For Covered Persons in Category 2, Medicare benefits are payable before any benefits are payable by the Plan. The benefits of the Plan will then be reduced by the full amount of all Medicare benefits the Covered Person is entitled to receive, whether or not they were actually enrolled for Medicare.

NONCONFINEMENT RULE

If a person who is eligible for coverage is confined as of the effective date of coverage, BFH is not responsible for the cost of the person's confinement to the extent that the confinement is covered by a prior insurer's extension of benefits provision.

EXTENSION OF BENEFITS
In the event this Contract is terminated, the Plan will continue to provide coverage for a Covered Person who is hospitalized or totally disabled due to an injury or illness that began while coverage under this Contract was in effect.

If You are hospitalized for a medical or surgical condition on the date Your coverage is discontinued or terminated or in the case of medical expense coverages, You will have continuation of coverage for covered services until the earliest of the following occurrences; 1) The date You are discharged from the hospital; 2) Until maximum benefits under the policy are received; or 3) At least twelve (12) months.

A total disability is a Member’s continuing inability as a result of injury or illness to perform the material duties and substantially engage in the duties of any occupation or other gainful activity for which Covered Person is qualified or could reasonably become qualified to perform by reason of education, training or experience. For Covered Persons not otherwise employed, Total Disability means the inability to engage in the normal activities of daily living for an individual of like age and gender by reason of any injury or illness that can be expected to be of a continuous or indefinite duration. Services are available only for the same injury or illness that caused the Covered Person to be totally disabled. Coverage for the disabling condition will be provided, without the requirement of any Premium payments, until the earliest of 1) the date the Covered Person is no longer totally disabled; 2) twelve (12) months from the date of termination; or 3) the date the Covered Person becomes eligible for the disabling condition under any employer or government sponsored health care plan; or 4) until maximum benefits under the policy are received.

LIABILITY OF SUCCEEDING INSURER
If coverage through BFH under the Certificate replaces the group policy of another insurer, the prior insurer shall remain liable only to the extent of its accrued liabilities, extension of benefits, and for persons who are under continued group health insurance coverage at the time the group policy terminates. The position of the prior insurer shall be the same whether the group policyholder secures

replacement coverage from a new insurer, self insures, or forgoes the provision of a group policy, except that termination of continued group health insurance coverage shall occur.

The liability of a succeeding insurer shall be as follows:

A. Each person who is eligible for coverage shall be covered by that insurer's plan on the effective date of coverage.

B. If a person, who is eligible for coverage, is confined as of the effective date of coverage under the succeeding insurer's plan and the succeeding insurer has a nonconfinement rule, the succeeding insurer is not responsible for the cost of the person's confinement to the extent that the confinement is covered by a prior insurer's extension of benefits provision.

C. The succeeding insurer, in applying any deductibles or waiting periods in its plan, shall give credit for the satisfaction or partial satisfaction of the same or similar provisions under a prior group policy. In the case of deductible provisions, the credit shall apply for the same or overlapping benefit periods and shall be given for expenses actually incurred and applied against the deductible provisions of the prior insurer's group policy during the ninety (90) days preceding the effective date of the succeeding insurer's group policy, but only to the extent these expenses are recognized under the terms of the succeeding insurer's group policy and are subject to similar deductible provisions.

D. If a determination of the prior insurer's benefit is required by the succeeding insurer, at the succeeding insurer's request the prior insurer shall furnish a statement of the benefits available or pertinent information sufficient to permit verification of the benefit determination or the determination itself by the succeeding insurer. For purposes of this section, benefits of the prior insurer's group policy shall be determined in accordance with all of the definitions, conditions, and covered expense provisions of the prior insurer's group policy rather than those of the succeeding insurer's group policy. The benefit determination shall be made as if coverage had not been replaced by the succeeding insurer.

SUBROGATION

The Plan intends to preserve and assert its rights to recovery for amounts or benefits paid to the Covered Person when a third (3rd) party or other payor may be liable for the cost of those benefits. Each of the following provisions are considered severable, and should any provision be found void, the remaining provisions shall be unaffected. The rights set forth in these provisions shall be enforced by the Plan to the fullest extent allowed by law.

To the extent that benefits of covered services are provided or paid under this Certificate, the Plan will be subrogated and succeed to any rights of recovery from, or, in the alternative, be reimbursed by a Covered Person for expenses incurred against any person, organization, or third (3rd) party who is or may be considered responsible for payment of the Covered Person’s injury, illness, or damages.

The Covered Person will pay the Plan all amounts recovered by lawsuit, settlement, or any other funds recovered from any liable third (3rd) party or payor, or his or her insurer, to the extent of the benefits provided or paid under this Certificate for

the Covered Person's injury, illness or damages. Sources of recovery from such third (3rd) parties or payors include automobile or recreational vehicle insurance coverage or benefits, including first (1st) party, underinsured and uninsured motorist coverage, business and homeowners' medical liability insurance coverage, medical payments under any automobile policy, premises or homeowners' medical payments coverage or premises or homeowners' insurance coverage, and any other payments from a source intended to compensate the Covered Person for injuries resulting from an accident or alleged negligence.

The Plan's right to subrogation or recovery of benefits paid by any liable party or third (3rd) party payor is first (1st) priority to any and all rights the Covered Person may be entitled to recover from such liable third (3rd) parties or payors, regardless of whether the Covered Person has been fully compensated for his or her loss, medical expenses, or damages. Under this provision, the Plan is entitled to be fully reimbursed for any and all benefits paid to the Covered Person from any recovery such Person may receive from a liable t third (3rd) party or payor. The Plan's right to reimbursement is not dependent upon whether liability is admitted, or whether the recovery is characterized as payment for medical expenses. The Covered Person shall hold in trust the proceeds of any recovery for the Plan, and shall pay the Plan such proceeds immediately upon their receipt by the Covered Person. Only those amounts received by the Covered Person that are in excess of the amounts paid in benefits by the Plan shall be retained by the Covered Person. No court costs or attorneys' fees may be deducted from the Plan's recovery without Our express written consent, and the Plan is not required to participate in or pay court costs or attorneys' fees to the attorney hired by You to pursue Your damage/personal injury claims.

As a condition of receipt of benefits paid by the Plan, the Covered Person is obligated to cooperate with the Plan and take such action, furnish such information and assistance, and execute such documents as the Plan may require to facilitate the enforcement of its rights. The Covered Person is prohibited from taking any action that would diminish or jeopardize the Plan's primary right of recovery under this provision. The Covered Person's failure to cooperate or otherwise comply with the terms of this provision will entitle the Plan to withhold benefits due the Covered Person under the Certificate of Coverage.

In addition, the Covered Person shall notify the Plan in writing within thirty (30) days if he/she files a personal injury claim, consults an attorney, or brings an action against a third (3rd) party. The Covered Person will also forward copies to the Plan of police reports or other documents received in connection with the accident or incident resulting in payment of benefits by the Plan. The Covered Person shall not settle or take any action that would otherwise compromise any claim against a potentially liable third (3rd) party without notifying the Plan in writing within thirty (30) days in advance of the action to be taken, and the Plan agrees in writing to such action. The cost of legal representation of the Covered Person shall not be assumed by the Plan, and the Plan shall not be responsible for payment of any legal fees for the Covered Person unless the Plan has agreed to do so in writing.

The Plan also has the right to file suit on behalf of the Covered Person against any third (3rd) party, corporation, or organization that may be deemed responsible or liable for the condition giving rise to the payment of benefits by the Plan; however,

the Plan is not obligated in any way to pursue this right independently or on Your behalf.

The Covered Person's failure to cooperate or otherwise comply with the terms of this provision will entitle the Plan to withhold, retract or deduct benefits due the Covered Person under the Certificate of Coverage.

NOTICE
Any notice required or permitted to be given by or to the Plan will be deemed appropriately given if in writing and either personally delivered or deposited in the United States mail with postage prepaid and addressed as follows:

Bluegrass Family Health, Inc.
Attn: Compliance Department
651 Perimeter Drive, Suite 300
Lexington, KY 40517

If to the Member: at the last known address as provided by the Member and/or as reflected on the records of the Plan.

PLAN/PROVIDER RELATIONS
The Plan does not furnish Covered Services, but only arranges for and/or provides benefits for Covered Services received by Covered Person. The Plan is not liable for any act or omission of any Provider. The Plan is not responsible for the failure or refusal of Covered Services to be rendered to a Covered Person on a day-to-day basis.

WOMEN'S HEALTH AND CANCER RIGHTS ACT
Services for reconstructive surgery following mastectomies are covered by the Plan and include coverage for:

A. Reconstruction of the breast on which the mastectomy has been performed;
B. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
C. Prostheses and physical complications of all stages of the mastectomy, including lymphedemas.

APPLICABLE LAWS
The provisions of this Certificate will be construed, administered, and enforced according to the applicable laws of the Commonwealth of Kentucky and any applicable federal laws.

PHYSICAL EXAMINATION
We reserve the right to cause You to be examined by an applicable Provider as often as may be reasonably required during the pendency of a claim.

GOVERNING LAW
This Certificate of coverage is made and will be interpreted under the laws of the Commonwealth of Kentucky and any applicable federal laws.

ASSIGNMENT
The Member may not assign his or her rights, including the right to receive benefits for Covered Services, under this Certificate.

MAJOR DISASTERS
In the event any major disaster, epidemic, or other circumstances beyond its control, the Plan will attempt to provide benefits for Covered Services insofar as practical, according to its best judgment and within the limitations of facilities and personnel then available. However, no liability or obligations are incurred for delay or failure to provide services due to lack of available facilities or personnel, if the lack is the result of the disaster, epidemic, or other circumstances beyond the Plan's control. Examples of such circumstances include partial or complete disruption of facilities (such as Hospitals, Urgent Care Centers, Ambulatory Surgical Center/Ambulatory Surgical Facility, Home Health Agencies, etc) and Providers, natural disasters, war, terrorism, riot, civil insurrection, labor disputes not within the control of the Plan, incapable or ineffective portion of a significant part of a Hospital or other Provider, or similar causes.

REPRESENTATION
In the absence of fraud, all statements made by applicants or the policyholders or by an insured person shall be deemed representations and not warranties, and that no statement made for the purpose of effecting insurance shall void such insurance or reduce benefits unless contained in a written instrument signed by the policyholder or the insured person, a copy of which has been furnished to such policyholder or to such person or his beneficiary.

SEVERABILITY
Should a court of competent jurisdiction subsequently invalidate any provision of this Certificate, the remaining provisions thereof will be given effect to the maximum extent permitted by law.

PLAN'S SOLE DISCRETION
The Plan may, in its sole discretion, cover services and supplies not specifically covered by the Certificate. This applies if the Plan determines such services and supplies are in lieu of more expensive services and supplies that would otherwise be requested for the care and treatment of a Covered Person.

MEMBER INQUIRY, COMPLAINT & APPEALS PROCESS

BFH provides a thorough process to address Member complaints and appeals. These administrative remedies must be exhausted before legal remedies are sought except in cases that BFH has waived the exhaustion requirements, or the Member has applied for external review at the same time as applying for an expedited internal appeal.

Inquiries and Complaints
If You have an inquiry or complaint regarding Your benefits or claims, You may contact a Customer Service Representative at (859) 269-4475 or (800) 787-2680.

Internal Appeals
BFH provides a full and fair review upon request for appeal, which includes the following:

A. Provide Covered Persons at least one hundred eighty (180) days following receipt of a notification of an Adverse Benefit Determination within which to appeal the determination;
B. Provide Covered Persons the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
C. Provide that a Covered Person shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Covered Person's claim for benefits; and
D. Provide for a review that takes into account all comments, documents, records, and other information submitted by the Covered Person relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

Additionally, the Plan will provide the Covered Person, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided to give the Covered Person a reasonable opportunity to respond prior to that date. Before BFH can issue a final internal Adverse Benefit Determination based on a new or additional rationale, the Covered Person must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal Adverse Benefit Determination is required to be provided to give the Covered Person a reasonable opportunity to respond prior to that date.

A Member, the Member's Authorized Representative, or a Provider acting on behalf of the Member, may initiate an internal appeal. An appeal is a request for review of an Adverse Benefit Determination or a Coverage Denial as defined below. An internal appeal may also be initiated if We fail to make a timely utilization review determination.

Adverse Benefit Determination means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for

a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on:

A. A determination of an individual's eligibility to participate in a plan or health insurance coverage, including, with respect to health benefit plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review;
B. A determination that a benefit is Experimental, Investigational, or not Medically Necessary or appropriate;
C. A determination that a benefit is not a covered benefit; or
D. The imposition of a Pre-Existing Condition exclusion, source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits.

An Adverse Benefit Determination includes any rescission of coverage whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time.

Coverage Denial means an insurer's determination that a service, treatment, drug, or device is specifically limited or excluded under the Covered Person's health benefit plan.

Initiating an Appeal

A request for an internal appeal must be submitted within one hundred eighty (180) calendar days of receipt of a determination. To initiate an internal appeal, please forward:

A. The initial denial letter;
B. The number of claims in question;
C. The date(s) of service;
D. A summary of any previous communication You have had with BFH regarding this denial; and
E. Any additional pertinent medical information

to the attention of the Appeals Coordinator, Bluegrass Family Health, 651 Perimeter Drive, Suite 300, Lexington, KY 40517.

A Member, the Member's Authorized Representative, or a Provider may request a board eligible or certified Physician in the appropriate specialty or subspecialty area to conduct the internal appeal relating to any denial of a service or coverage. Within thirty (30) days of receipt of the internal appeal request, We will send a written decision to the Member or their Authorized Representative, and if applicable, the Member's Provider.

All claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in the decision. In addition to ensuring impartiality of the medical expert making the appeals decision, the federal rules provide that insurer decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (claims adjudicator or medical expert) must not be made based on the likelihood that the individual will support a denial of benefits. An expedited appeal (or urgent care appeal) is deemed necessary when the Member is hospitalized, or in

the opinion of the treating Provider, a review under a standard timeframe could, in the absence of immediate medical attention; result in any of the following:

A. Place the health of the Covered Person or, with respect to a pregnant woman, the health of the Covered Person or the unborn child in serious jeopardy;
B. Cause serious impairment to bodily functions or serious dysfunction of a bodily organ or part;
C. Subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is subject of the claim; or
D. As related to a recommended or requested service determined to be Experimental or Investigational, cause the service to be significantly less effective if not promptly initiated.

An expedited appeal may be requested orally and followed up by an abbreviated written request by a Member, the Member's Authorized Representative or a Provider acting on behalf of a Member by contacting the Appeals Coordinator at (859) 269-4475 or (800) 787-2680, or in writing by sending the request to the Appeals Coordinator at Bluegrass Family Health, 651 Perimeter Drive, Suite 300, Lexington, KY 40517. An internal appeal decision will be rendered not later than seventy-two (72) hours after the receipt of the request for an expedited internal appeal.

Any additional pertinent information may be submitted for consideration during the internal appeal process. If You or Your Provider has new clinical information regarding Your appeal, You may provide it prior to the initiation of an external review. BFH will then have five (5) business days from the date of receipt of the new information to render a decision based on the new information. Following that decision, You have one hundred and twenty (120) calendar days to initiate an external review of an Adverse Determination.

If Our decision is to uphold a Coverage Denial, the Member, the Member's Authorized Representative, or a Provider may contact the Kentucky Department of Insurance (DOI), Health and Life Division, P.O. Box 517, Frankfort, Kentucky 40602, and request a review of Our decision. The DOI will make a determination as to whether the service should or should not be covered. If the DOI determines the disputed service should be covered, they may direct Us to either cover the service or offer external review to resolve the issue.

External Review by an Independent Review Entity (IRE)

The Member, the Member's Authorized Representative, or a Provider acting on behalf of and with the consent of the Member may request an external review by an independent review entity (IRE) of a claim denied, on the basis that the service is not Medically Necessary or is Experimental or Investigational, may be made within one hundred twenty (120) calendar days after exhausting the internal appeal process, if the following conditions are met:

A. BFH or Our designee has rendered a Medical Necessity, or Experimental or Investigational denial of service or coverage;
B. The Covered Person has completed our internal appeal process, or BFH has failed to make a timely determination or notification; and

C. The Covered Person was eligible on the date of service, or if a prospective denial, the Covered Person was enrolled and eligible to receive covered benefits under the health benefit plan on the date the proposed service was requested.

The Covered Person will, however, be responsible for a twenty-five dollar ($25) filing fee to be paid to the IRE, which may be waived in case of financial hardship, or refunded if the IRE finds in favor of the Covered Person. Please do not send this fee to BFH. An external review shall not be afforded if:

A. The subject of the Covered Person's denial has previously gone through the external review process and the IRE found in our favor; and
B. No relevant new clinical information has been submitted to BFH since the IRE found in our favor.

Written requests for external review shall be submitted to External Review, Appeals Department, Bluegrass Family Health, 651 Perimeter Drive, Suite 300, Lexington, KY 40517. If You have any questions regarding the external review process please contact the Appeals Coordinator at (859) 269-4475 or (800) 787-2680. As part of the written request, the Covered Person must complete an ***Authorization for the Use and Disclosure of Individually Identifiable Health Information to an Independent Review Entity (IRE) form*** to obtain all necessary medical records from both BFH and any Provider utilized for review purposes regarding the decision to deny, limit, reduce, or terminate coverage.

All medical records involved in the external review process shall be deemed confidential.

If a dispute arises between the Plan and a Member regarding the right to an external review, the Member may file a complaint with the DOI. The DOI shall render a decision within five (5) days of receipt of the complaint.

We will be responsible for the cost of the external review. We will assign external reviews to IREs on a rotating basis such that We do not utilize the same IRE for two (2) consecutive reviews.

The IRE will send a written decision to the Member within twenty-one (21) calendar days of receiving the request for external review. An extension of up to fourteen (14) calendar days may be allowed if the Member and BFH are in agreement.

An expedited external review process is available if the Covered Person is hospitalized or, in the opinion of the treating Provider, a review under a standard timeframe could, in the absence of immediate medical attention; result in any of the following:

A. Place the health of the Covered Person or, with respect to a pregnant woman, the health of the Covered Person or the unborn child in serious jeopardy;
B. Cause serious impairment to bodily functions or serious dysfunction of a bodily organ or part;
C. Subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is subject of the claim; or

D. As related to a recommended or requested service determined to be Experimental or Investigational, cause the service to be significantly less effective if not promptly initiated.

An expedited external review may be requested orally and followed up by an abbreviated written request. In the case of an expedited external review, the IRE will make a decision within twenty-four (24) hours from receiving all of the information required from Us. An extension of up to twenty-four (24) hours may be allowed if the Member and BFH agree.

The request for an internal appeal or an external review and any supporting documentation must be submitted to the following address: Appeals Coordinator, Bluegrass Family Health, 651 Perimeter Drive, Suite 300, Lexington, Kentucky 40517.

Bluegrass **Family Health**

651 Perimeter Drive, Suite 300, Lexington, KY 40517
(859) 269-4475 or (800) 787-2680
www.bgfh.com

Bluegrass Family Health

COVERED PREVENTIVE GUIDELINES
Effective December 1, 2011

SERVICE	FREQUENCY	RESTRICTION	AGE REQUIREMENTS
Aortic Aneurysm Screening, Abdominal ultrasound	ONCE	MALE	65 YRS to 75 YRS
Alcohol Misuse Counseling	1/YEAR		
Blood Pressure Screening			Adults age 18 and older
Breast & Ovarian Cancer Susceptibility, Genetic Risk Assessment & BRCA Counseling and Evaluation		FEMALE	
Breast Cancer Screening, Mammography	1/YEAR		≥30 YRS
Breastfeeding Counseling			
Cholesterol/Lipid Screening	1/YEAR		Men (age 20 to 35 if increased risk or age 35 and up if normal risk) Women (age 20 to 45 if increased risk, 45 and up if normal risk)
Colorectal Cancer Screening: Colonoscopy, Flexible Sigmoidoscopy, Digital Rectal Exam, Air Contrast Barium Enema, CT Colonography (1), Stool DNA Test, gFOBT or FIT (2)	1/YEAR		≥50 YRS (or less than 50 years of age if at high risk for colorectal cancer according to the current colorectal cancer screening guidelines of the American Cancer Society)
Dental Caries Chemical Prevention: Oral Fluoride Supplementation, Preschool Children			6 months up to 5 YRS
Depression Screening: Adolescents, Adults			
Diabetes Screening			asymptomatic adults with sustained blood pressure >135/80
Gynecological Exam, Including Cervical Cytology (PAP test)	1/YEAR	FEMALE	Per current ACS recommendations
Healthy Diet Counseling	1/YEAR		adult patients with hyperlipidemia or other known risk factors for cardiovascular and diet-related chronic disease
Newborn and Infant Office Visits	PER MD		0-24 MOS
Newborns: Hearing Loss Screening, Hemoglobinopathies Screening, Hypothyroidism Screening, PKU Screening, Sickle Cell Disease Screening			Newborns
Obesity Screening and Counseling: Children, Adults	1/YEAR		all adults and children age 6 and up
Osteoporosis Screening (Bone Density Study)	1/YEAR	FEMALE	≥35 YRS
Pregnancy - Anemia Screening, Bacteriuria Screening, Hepatitis B Screening, Rh Incompatibility, Folic Acid Supplementation, Tobacco Use Counseling		FEMALE	
Prostate Exam	1/YEAR	MALE	
Prostate Specific Antigen Test (PSA)	1/YEAR	MALE	≥50 YRS
Routine Office Visits	1/YEAR		
Sexually Transmitted Disease (STD) Counseling & Screening Including HIV, Chlamydia, Gonorrhea, Syphilis	1/YEAR		All sexually active adolescents and adults at increased risk of STD
Tobacco Use Counseling: Non-Pregnant Adults, Pregnant Women	1/YEAR		
Visual Acuity Screening: Children	1/YEAR		younger than age 5 YRS
Well Child Office Visits	1/YEAR		24 MOS-18YRS

The following recommended services will be provided without cost-sharing when delivered by an in-network provider and as described in your schedule of benefits.

SERVICE	FREQUENCY	RESTRICTION	AGE REQUIREMENTS
Aspirin to Prevent CVD			Men aged 45 to 79, women ages 55 to 79
Folic Acid Supplementation		FEMALE	all women planning or capable of pregnancy
Iron Supplementation: Children			6 to 12 months at increased risk of anemia

Bluegrass Family Health

COVERED PREVENTIVE GUIDELINES
Effective December 1, 2011

IMMUNIZATIONS/VACCINES	RESTRICTION	AGE REQUIREMENTS
Diphtheria, Tetanus, Pertussis (DTaP)		Minimum age 6 weeks, maximum age 7 YRS
Haemophilus influenza type B (HIB)		Minimum age 6 weeks
Hepatitis A		Minimum age 12 months
Hepatitis B		
Human Papilloma Virus (HPV)		ages 9 to 26 YRS
Influenza	AT MD OFFICE	Minimum age 6 months for trivalent inactivated influenza vaccine (TIV); 2 years for live, attenuated influenza vaccine (LAIV)
Meningococcal		Ages 2 YRS and up
Measles, Mumps, Rubella (MMR)		Minimum age 12 months
Pneumococcal		Minimum age 6 weeks for pneumococcal conjugate vaccine (PCV); 2 YRS for pneumococcal polysaccharide vaccine (PCV)
Polio Vaccine, Inactivated (IPV)		Minimum age 8 weeks
Rotavirus		first dose to be given between 6 wks and 14 wks of age
Tetanus		
Varicella		Minimum age 12 months
Zoster		Ages 60 YRS and older

The list of Covered Preventive Services reflects A and B Recommendations from the U.S. Preventive Services Task Force that are relevant for implementing the Affordable Care Act. These may be found on the internet at http://www.ahrq.gov/clinic/uspstf/uspsabrecs.htm . This list of Covered Preventive Services may be subject to change based on recommendations of the most current medical literature and the US Preventive Services Task Force. Items on this list may be added after review by Bluegrass Family Health.

FOOTNOTES

(1) Requires Precertification

(2) Guaiac Fecal Occult Blood Test, Fecal Immunochemical Test

Adolescent and childhood immunizations are covered per 2011 recommended age-appropriate immunization schedules approved by the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, and the American Academy of Family Practice.

BluegrassFamily Health

651 Perimeter Drive, Suite 300, Lexington, KY 40517

PRESCRIPTION DRUG RIDER [Prescription Rider Name] [Group Name (Special Rider Name paired with Specific Plan)] [This rider is designed with (Aggregate) OR (Embedded) Accumulators.]

The Certificate of Coverage is hereby amended by this rider as of the date the rider is issued. The benefits herein are supplemental to the benefits described in the Benefits section of the Certificate. Benefits are subject to Plan Delivery System Rules, Exclusions, limitations, and all other provisions of the Certificate, except as specifically provided for in the rider.

The services provided by this rider are subject to:

In-Network

	Prescription Drugs (30 day supply) - Retail: [Includes diabetic test strip]	**Prescription Drugs (90 day supply) - Mail Order: *[1 – 3 times the Rx Copay AND/OR maximum and minimum]* [Includes diabetic test strip]**
□	[$0 - $50 Copay] **AND/OR** [(0% - 50%) Coinsurance] 1st Tier	[$0 - $150 Copay] **AND/OR** [(0% - 50%) Coinsurance] 1st Tier
	[$0 - $100 Copay] **AND/OR** [(0% - 50%) Coinsurance] 2nd Tier	[$0 - $300 Copay] **AND/OR** [(0% - 50%) Coinsurance] 2nd Tier
	[$0 - $100 Copay] **AND/OR** [(0% - 50%) Coinsurance][; ($0 - $1,000) maximum per prescription] 3rd Tier[1]	[$0 - $300 Copay] **AND/OR** [(0% - 50%) Coinsurance][; ($0 - $3,000) maximum per prescription] 3rd Tier[1]
	OR	
□	[$0 - $50 Copay] **AND/OR** [(0% - 50%) Coinsurance] 1st Tier	[$0 - $150 Copay] **AND/OR** [(0% - 50%) Coinsurance] 1st Tier
	[$0 - $100 Copay] **AND/OR** [(0% - 50%) Coinsurance] 2nd Tier	[$0 - $300 Copay] **AND/OR** [(0% - 50%) Coinsurance] 2nd Tier
	[$0 - $100 Copay] **AND/OR** [(0% - 50%) Coinsurance] 3rd Tier	[$0 - $300 Copay] **AND/OR** [(0% - 50%) Coinsurance] 3rd Tier
	[$0 - $200 Copay] **AND/OR** [(0% - 50%) Coinsurance][; ($0 - $2,500) maximum per prescription] 4th Tier[1]	[$0 - $600 Copay] **AND/OR** [(0% - 50%) Coinsurance][; ($0 - $5,000) maximum per prescription] 4th Tier[1]
	OR	
□	($0 - $50) Copay after Medical Deductible 1st Tier	($0 - $150) Copay after Medical Deductible 1st Tier
	($0 - $100) Copay after Medical Deductible 2nd Tier	($0 - $300) Copay after Medical Deductible 2nd Tier
	($0 - $100) Copay after Medical Deductible [; ($0 - $1,000) maximum per prescription] 3rd Tier	($0 - $300) Copay after Medical Deductible [; ($0 - $3,000) maximum per prescription] 3rd Tier
	[$0 - $200 Copay after Medical Deductible] **AND/OR** [0% - 50% Coinsurance] [($0 - $1,000) maximum per prescription] 4th tier [($0 - $20,000) Annual out of pocket limit on 4th Tier only]	[$0 - $600 Copay after Medical Deductible] **AND/OR** [0% - 50% Coinsurance] [($0 - $3,000) maximum per prescription] 4th tier [($0 - $20,000) Annual out of pocket limit on 4th Tier only]
	OR	

□	[$0 - $50 Copay] **AND/OR** [(0% - 50%) Coinsurance] 1st Tier	[$0 - $150 Copay] **AND/OR** [(0% - 50%) Coinsurance] 1st Tier
	[$0 - $100 Copay] **AND/OR** [(0% - 50%) Coinsurance] 2nd Tier	[$0 - $300 Copay] **AND/OR** [(0% - 50%) Coinsurance] 2nd Tier
	[$0 - $100 Copay] **AND/OR** [(0% - 50%) Coinsurance][; ($0 - $1,000) maximum per prescription] 3rd Tier	[$0 - $300 Copay] **AND/OR** [(0% - 50%) Coinsurance][; ($0 - $3,000) maximum per prescription] 3rd Tier
	[$0 - $200 Copay] AND/OR [0% - 50% Coinsurance] [($0 - $1,000) maximum per prescription] 4th tier [($0 - $20,000) Annual out of pocket limit on 4th Tier only]	[$0 - $600 Copay] AND/OR [0% - 50% Coinsurance] [($0 - $3,000) maximum per prescription] 4th tier [($0 - $20,000) Annual out of pocket limit on 4th Tier only]
	OR	
□	[$0 - $50 Copay] **AND/OR** [(0% - 50%) Coinsurance] 1st Tier	[$0 - $150 Copay] **AND/OR** [(0% - 50%) Coinsurance] 1st Tier
	[$0 - $100 Copay] **AND/OR** [(0% - 50%) Coinsurance] 2nd Tier	[$0 - $300 Copay] **AND/OR** [(0% - 50%) Coinsurance] 2nd Tier
	[$0 - $100 Copay] **AND/OR** [(0% - 50%) Coinsurance][; ($0 - $1,000) maximum per prescription] 3rd Tier[1]	[$0 - $300 Copay] **AND/OR** [(0% - 50%) Coinsurance][; ($0 - $3,000) maximum per prescription] 3rd Tier **[1]**
	[$0 - $1,000] Individual deductible; [$0 - $3,000] Family deductible; then [0% - 50% Coinsurance on total cost for 30 day supply]; [($0 - $500) minimum per prescription (or actual cost of prescription if less than minimum); ($0 - $1,000) maximum per prescription] 4th tier [($0 - $20,000) Annual out of pocket limit on 4th Tier only]	[$0 - $1,000] Individual deductible; [$0 - $3,000] Family deductible; then [0% - 50% Coinsurance on total cost for 90 day supply]; [($0 - $1,500) minimum per prescription (or actual cost of prescription if less than minimum); ($0 - $3,000) maximum per prescription] 4th tier [($0 - $20,000) Annual out of pocket limit on 4th Tier only]
	OR	
□	[$0 - $50 Copay] **AND/OR** [(0% - 50%) Coinsurance] 1st Tier	[$0 - $150 Copay] **AND/OR** [(0% - 50%) Coinsurance] 1st Tier
	[$0 - $100 Copay] **AND/OR** [(0% - 50%) Coinsurance] 2nd Tier	[$0 - $300 Copay] **AND/OR** [(0% - 50%) Coinsurance] 2nd Tier
	[($0 - $1,000) Individual deductible; ($0 - $3,000) Family deductible] [; then] [0% - 50% Coinsurance] [on total cost for 30 day supply;] [($0 - $500) minimum per prescription (or actual cost of prescription if less than minimum); ($0 - $1,000) maximum per prescription] 3rd tier [($0 - $20,000) Annual out of pocket limit on 3rd Tier only]	[($0 - $1,000) Individual deductible; ($0 - $3,000) Family deductible] [; then] [0% - 50% Coinsurance] [on total cost for 90 day supply;] [($0 - $1,500) minimum per prescription (or actual cost of prescription if less than minimum); ($0 - $3,000) maximum per prescription] 3rd tier [($0 - $20,000) Annual out of pocket limit on 3rd Tier only]
	OR	
□	[$0 - $50 Copay] **AND/OR** [(0% - 50%) Coinsurance] 1st Tier	[$0 - $150 Copay] **AND/OR** [(0% - 50%) Coinsurance] 1st Tier
	[$0 - $100 Copay] **AND/OR** [(0% - 50%) Coinsurance] 2nd Tier	[$0 - $300 Copay] **AND/OR** [(0% - 50%) Coinsurance] 2nd Tier
	[($0 - $1,000) Individual deductible; ($0 - $3,000) Family deductible] [; then] [0% - 50% Coinsurance] [on total cost for 30 day supply;] [($0 - $500) minimum per prescription (or actual cost of prescription if less than minimum); ($0 - $1,000) maximum per prescription] 3rd tier [($0 - $20,000) Annual out of pocket limit on 3rd Tier only]	[($0 - $1,000) Individual deductible; ($0 - $3,000) Family deductible] [; then] [0% - 50% Coinsurance] [on total cost for 90 day supply;] [($0 - $1,500) minimum per prescription (or actual cost of prescription if less than minimum); ($0 - $3,000) maximum per prescription] 3rd tier [($0 - $20,000) Annual out of pocket limit on 3rd Tier only]
	[0% - 50% Coinsurance] [($0 - $1,000) maximum per prescription] 4th tier [($0 - $20,000) Annual out of pocket limit on 4th Tier only]	[0% - 50% Coinsurance] [($0 - $3,000) maximum per prescription] 4th tier [($0 - $20,000) Annual out of pocket limit on 4th Tier only]

	OR	
□	(0% - 50%) Coinsurance	No Coverage
	OR	
□	[($0 - $1,000) Individual deductible; ($0 - $3,000) Family deductible] [; then] [(0% - 50%) Coinsurance] [per prescription for 30 day supply] [on total cost for 30 day supply;] [($0 - $500) minimum per prescription (or actual cost of prescription if less than minimum); ($0 - $1,000) maximum per prescription] [($0 - $20,000) Annual out of pocket limit]	[($0 - $1,000) Individual deductible; ($0 - $3,000) Family deductible] [; then] [(0% - 50%) Coinsurance] [per prescription for 90 day supply] [on total cost for 90 day supply;] [($0 - $1,500) minimum per prescription (or actual cost of prescription if less than minimum); ($0 - $3,000) maximum per prescription] [($0 - $20,000) Annual out of pocket limit]
	OR	
□	Subject to the In-Network Medical Deductible, then In-Network Coinsurance as specified on the Schedule of Benefits 1st, 2nd & 3rd Tier[1]	Subject to the In-Network Medical Deductible, then In-Network Coinsurance as specified on the Schedule of Benefits 1st, 2nd & 3rd Tier[1]
	OR	
□	Subject to the In-Network Medical Deductible as specified on the Schedule of Benefits; then (0% - 50%) coinsurance 1st, 2nd & 3rd Tier	Subject to the In-Network Medical Deductible as specified on the Schedule of Benefits; then (0% - 50%) coinsurance 1st, 2nd & 3rd Tier
	OR	
□	No Coverage	No Coverage
	OR	
□	[$0 - $50 Copay] **AND/OR** [(0% - 50%) Coinsurance] [Lower-cost generics and brands] [(generally generic)] 1st Tier	[$0 - $150 Copay] **AND/OR** [(0% - 50%) Coinsurance] [Lower-cost generics and brands] [(generally generic)] 1st Tier
	($0 - $1,000) deductible per member; then **Copayments AND/OR Coinsurance** [2nd and 3rd Tiers] **OR** [2nd, 3rd and 4th Tiers]	($0 - $1,000) deductible per member; then **Copayments AND/OR Coinsurance** [2nd and 3rd Tiers] **OR** [2nd, 3rd and 4th Tiers]
	[$0 - $100 Copay] **AND/OR** [(0% - 50%) Coinsurance] 2nd Tier [Higher-cost generics and brands]	[$0 - $300 Copay] **AND/OR** [(0% - 50%) Coinsurance] 2nd Tier [Higher-cost generics and brands]
	[$0 - $100 Copay] **AND/OR** [(0% - 50%) Coinsurance; ($0 - $1,000) maximum per prescription] 3rd Tier [High-cost brands]	[$0 - $300 Copay] **AND/OR** [(0% - 50%) Coinsurance; ($0 - $3,000) maximum per prescription] 3rd Tier [High-cost brands]
	[$0 - $200 Copay] **AND/OR**[(0% - 50%) Coinsurance 4th Tier][: Up to ($0 - $1,000) per Prescription per month.] [Mostly high cost, self administered injectable medications and high technology drugs][($0 - $20,000) Annual out of pocket limit on 4th Tier only]	[$0 - $600 Copay] AND/OR [(0% - 50%) Coinsurance 4th Tier][: Up to ($0 - $3,000) per Prescription per month.] [Mostly high cost, self administered injectable medications and high technology drugs][($0 - $20,000) Annual out of pocket limit on 4th Tier only]

	OR	
□	($0 - $1,000) deductible per member; **[no family maximum;]** then **Copayments AND/OR Coinsurance** [1st, 2nd and 3rd Tiers] **OR** [1st, 2nd, 3rd and 4th Tiers]	($0 - $1,000) deductible per member; **[no family maximum;]** then **Copayments AND/OR Coinsurance** [1st, 2nd and 3rd Tiers] **OR** [1st, 2nd, 3rd and 4th Tiers]
	[$0 - $50 Copay] **AND/OR** [(0% - 50%) Coinsurance] [Lower-cost generics and brands] [(generally generic)] 1st Tier	[$0 - $150 Copay] **AND/OR** [(0% - 50%) Coinsurance] [Lower-cost generics and brands] [(generally generic)] 1st Tier
	[$0 - $100 Copay] **AND/OR** [(0% - 50%) Coinsurance] 2nd Tier [Higher-cost generics and brands]	[$0 - $300 Copay] **AND/OR** [(0% - 50%) Coinsurance] 2nd Tier [Higher-cost generics and brands]
	[$0 - $100 Copay] **AND/OR** [(0% - 50%) Coinsurance; ($0 - $1,000) maximum per prescription] 3rd Tier [High-cost brands]	[$0 - $300 Copay] **AND/OR** [(0% - 50%) Coinsurance; ($0 - $3,000) maximum per prescription] 3rd Tier [High-cost brands]
	[(0% - 50%) Coinsurance 4th Tier][: Up to ($0 - $1,000) per Prescription per month.] [Mostly high cost, self administered injectable medications and high technology drugs][($0 - $20,000) Annual out of pocket limit on 4th Tier only]	[(0% - 50%) Coinsurance 4th Tier][: Up to ($0 - $3,000) per Prescription per month.] [Mostly high cost, self administered injectable medications and high technology drugs][($0 - $20,000) Annual out of pocket limit on 4th Tier only]
	OR	
□	[$0 - $50 Copay] **AND/OR** [(0% - 50%) Coinsurance] [Lower-cost generics and brands] [(generally generic)] 1st Tier	[$0 - $150 Copay] **AND/OR** [(0% - 50%) Coinsurance] [Lower-cost generics and brands] [(generally generic)] 1st Tier
	[($0 - $1,000) Individual deductible; ($0 - $3,000) Family deductible] then Copayments **AND/OR** Coinsurance [2nd and 3rd Tiers] **OR** [2nd, 3rd and 4th Tiers]	[($0 - $1,000) Individual deductible; ($0 - $3,000) Family deductible] then Copayments **AND/OR** Coinsurance [2nd and 3rd Tiers] **OR** [2nd, 3rd and 4th Tiers]
	[$0 - $100 Copay] **AND/OR** [(0% - 50%) Coinsurance] 2nd Tier [Higher-cost generics and brands]	[$0 - $300 Copay] **AND/OR** [(0% - 50%) Coinsurance] 2nd Tier [Higher-cost generics and brands]
	[$0 - $100 Copay] **AND/OR** [(0% - 50%) Coinsurance; ($0 - $1,000) maximum per prescription] 3rd Tier [High-cost brands]	[$0 - $300 Copay] **AND/OR** [(0% - 50%) Coinsurance; ($0 - $3,000) maximum per prescription] 3rd Tier [High-cost brands]
	[(0% - 50%) Coinsurance 4th Tier][: Up to ($0 - $1,000) per Prescription per month.] [Mostly high cost, self administered injectable medications and high technology drugs][($0 - $20,000) Annual out of pocket limit on 4th Tier only]	[(0% - 50%) Coinsurance 4th Tier][: Up to ($0 - $3,000) per Prescription per month.] [Mostly high cost, self administered injectable medications and high technology drugs][($0 - $20,000) Annual out of pocket limit on 4th Tier only]

	OR	
□	[($0 - $1,000) Individual deductible; ($0 - $3,000) Family deductible] then Copayments AND/OR Coinsurance [1st, 2nd and 3rd Tiers] OR [1st, 2nd, 3rd and 4th Tiers]	[($0 - $1,000) Individual deductible; ($0 - $3,000) Family deductible] then Copayments AND/OR Coinsurance [1st, 2nd and 3rd Tiers] OR [1st, 2nd, 3rd and 4th Tiers]
	[$0 - $50 Copay] **AND/OR** [(0% - 50%) Coinsurance] [Lower-cost generics and brands] [(generally generic)] 1st Tier	[$0 - $150 Copay] **AND/OR** [(0% - 50%) Coinsurance] [Lower-cost generics and brands] [(generally generic)] 1st Tier
	[$0 - $100 Copay] **AND/OR** [(0% - 50%) Coinsurance] 2nd Tier [Higher-cost generics and brands]	[$0 - $300 Copay] **AND/OR** [(0% - 50%) Coinsurance] 2nd Tier [Higher-cost generics and brands]
	[$0 - $100 Copay] **AND/OR** [(0% - 50%) Coinsurance; ($0 - $1,000) maximum per prescription] 3rd Tier [High-cost brands]	[$0 - $300 Copay] **AND/OR** [(0% - 50%) Coinsurance; ($0 - $3,000) maximum per prescription] 3rd Tier [High-cost brands]
	[(0% - 50%) Coinsurance 4th Tier][: Up to ($0 - $1,000) per Prescription per month.] [Mostly high cost, self administered injectable medications and high technology drugs][($0 - $20,000) Annual out of pocket limit on 4th Tier only]	[(0% - 50%) Coinsurance 4th Tier][: Up to ($0 - $3,000) per Prescription per month.] [Mostly high cost, self administered injectable medications and high technology drugs][($0 - $20,000) Annual out of pocket limit on 4th Tier only]
	OR	
□	[$0 - $50] Copay [($0 - $500) minimum per prescription (or actual cost of prescription if less than minimum); ($0 - $1,000) maximum per prescription] Generic [$0 - $100] Copay [($0 - $500) minimum per prescription (or actual cost of prescription if less than minimum); ($0 - $1,000) maximum per prescription] Single Source Brand [0% - 50%] Coinsurance [($0 - $500) minimum per prescription (or actual cost of prescription if less than minimum); ($0 - $1,000) maximum per prescription] All other prescription medications other than drugs excluded per COC	[$0 - $150] Copay [($0 - $1,500) minimum per prescription (or actual cost of prescription if less than minimum); ($0 - $3,000) maximum per prescription] Generic [$0 - $300] Copay [($0 - $1,500) minimum per prescription (or actual cost of prescription if less than minimum); ($0 - $3,000) maximum per prescription] Single Source Brand [0% - 50%] Coinsurance [($0 - $1,500) minimum per prescription (or actual cost of prescription if less than minimum); ($0 - $3,000) maximum per prescription] All other prescription medications other than drugs excluded per COC
	OR	
□	[$0 - $50 Copay] **AND/OR** [(0% - 50%) Coinsurance] 1st Tier	[$0 - $150 Copay] **AND/OR** [(0% - 50%) Coinsurance] 1st Tier
	[$0 - $100 Copay] **AND/OR** [(0% - 50%) Coinsurance] 2nd Tier	[$0 - $300 Copay] **AND/OR** [(0% - 50%) Coinsurance] 2nd Tier
	[$0 - $1,000] Individual deductible; [$0 - $3,000] Family deductible; then [0% - 50% Coinsurance on total cost for 30 day supply]; [($0 - $500) minimum per prescription (or actual cost of prescription if less than minimum); ($0 - $1,000) maximum per prescription] 3rd tier [($0 - $20,000) Annual out of pocket limit on **3rd** Tier only]	[$0 - $1,000] Individual deductible; [$0 - $3,000] Family deductible; then [0% - 50% Coinsurance on total cost for 90 day supply]; [($0 - $1,500) minimum per prescription (or actual cost of prescription if less than minimum); ($0 - $3,000) maximum per prescription] 3rd tier [($0 - $20,000) Annual out of pocket limit on **3rd** Tier only]

	Out-of-Network	
	Prescription Drugs (30 day supply) - Retail:	**Prescription Drugs (90 day supply) - Mail Order:**
	No Coverage	No Coverage

[1 This rider includes - Erectile Dysfunctional Drugs with Quantity Limit of (0 - 30) pills per (0 - 90) days.]

[This rider includes an Aggregate Deductible. Benefits are payable after the individual deductible has been met for single coverage. For family coverage, benefits are payable after the family deductible has been met. Deductible limits for in-network and out-of-network services calculate separately.] **OR**

[This rider includes an Embedded Deductible. After the individual deductible has been met by one family member, benefits are payable for that individual. For family coverage, benefits are payable after any one family member meets the individual deductible, or any combination of family members meets the family deductible. Deductible limits for in-network and out-of-network services calculate separately.]

Out of Pocket Limit - Payments made by the Covered Person for services provided by this rider □ [do] OR [do not] apply toward the Out of Pocket limit specified in the Schedule of Benefits.

Prescription Drug Overrides **-** Bluegrass Family Health (BFH) provides prescription drug overrides as required by applicable state law. Prescription drug overrides do not apply to any controlled medication. Only twelve (12) fills per year of a medication are allowed, regardless of override and no more than three (3) refills of a covered drug may be obtained within a ninety (90) day period.

Preferred Drug List - A copy of the Preferred Drug List is available online at www.bgfh.com, or by contacting Customer Service at 859-269-4475 or toll free at 800-787-2680.

[* Under this pharmacy coverage plan, a deductible and out-of-pocket maximum apply. Please refer to the medical plan documents for the annual deductible & out-of-pocket maximum amounts. The deductible and the out-of-pocket maximum include both medical and pharmacy expenses. This means that you will pay the full amount we have contracted with the pharmacy to charge you for your prescriptions (not just your copayment), until you have satisfied the deductible. Once the deductible is satisfied, your prescriptions will be subject to the copayments listed. If you reach the out-of-pocket maximum, you will not be required to pay a copayment.]