THE KENTUCKY STANDARD HEALTH BENEFIT PLAN

Department of Insurance
Health and Life Division
2011 Edition

THE FOLLOWING STANDARD FORMAT IS REQUIRED OF ALL CARRIERS. OTHER STANDARD/NONSTANDARD PROCESSES ARE OUTLINED IN THE FOLLOWING PAGES.

[CERTIFICATE OF COVERAGE] [POLICY] FORMAT

POLICY COVER SHEET

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*Note: All extension of benefit provisions for group policies must include the following definitions for disability and total disability: Disability means the state of being hospitalized on the date for replacement coverage. Total disability means your continuing inability as a result of injury or sickness to perform the material and substantial duties of any occupation for which you are suited by reason of education, training or experience or, if not employed, you are confined to

a Hospital or completely incapacitated when coverage under the certificate would otherwise terminate.

[XXX HEALTH MAINTENANCE ORGANIZATION] [XXX INSURANCE COMPANY]
KENTUCKY REQUIRED COVER SHEET

READ YOUR [CERTIFICATE] [POLICY] CAREFULLY. This Cover Sheet provides only a brief outline of some of the important features of your Policy.

(Group Only) [This Certificate of Coverage is not a legal document. The Plan Document maintained by the group is the legal Contract and this Certificate is subject to its terms and conditions. In the event of conflict, the provisions of the Plan Document will prevail over this Certificate.]

(Individual Only) [This Policy is a legal Contract between the Member and the [Insurance Company] [Health Maintenance Organization].

IT IS, THEREFORE, IMPORTANT THAT YOU READ YOUR [CERTIFICATE] [POLICY] CAREFULLY.

This [Certificate] [Policy] Is Issued In Accordance With the Provisions of the Kentucky Standard [Fee for Service] [PPO] [POS] [HMO] Health Benefit Plan

No individually insured person will be required to replace an individual Policy with group coverage on becoming eligible for group coverage that is not provided by an employer. In a situation where a person holding individual coverage is offered or becomes eligible for group coverage not provided by an employer, the person holding the individual coverage will have the option of remaining individually insured, as the policyholder may decide. This will apply in any such situation that may arise through any health purchasing alliance, an association, an affiliated group, the Kentucky state employee health insurance plan, or any other entity.

(Individual Only) [This Policy is Guaranteed Renewable. Guaranteed Renewable Means That the Policy Must Be Renewed Except for Non-Payment of Premium, Fraud or Misrepresentation, Intentional and Abusive Non-Compliance with Plan Provisions, [Service Area Limitations], Uniform Discontinuance of a Type of Coverage, or if the [Insurance Company][Health Maintenance Organization] Ceases to do Business in Kentucky. Review Your Policy Carefully for Further Information on These Provisions.] [Modifications to the Plan May be Made at the Time of Renewal or as Required by Law.]

(Group only) [This is a Certificate of Coverage. This Certificate of Coverage Is Issued Under a Policy Which is Guaranteed Renewable at the Option of the Group Policyholder. The Coverage of a Member Can Be Terminated for Non-Payment of Premium, Fraud or Misrepresentation, Intentional and Abusive Non-Compliance with Plan Provisions, [Service Area Limitations], Uniform Discontinuance of a Type of Coverage, or if the [Insurance Company][Health Maintenance Organization] Ceases to do Business in Kentucky. Review Your Certificate Carefully for Further Information on These Provisions.] [Modifications to the Plan May be Made at the Time of Renewal or as Required by Law.]

(Individual Health Maintenance Organizations Certificates/Insurance Policies Only)

If you are not satisfied with this Policy for any reason, you may return it within [at least 10] days of its delivery for a full refund of Premium paid. Return can be made to the [Insurance Company] [Health Maintenance Organization] at its principal or branch office or to the Agent.

A TABLE OF CONTENTS FOLLOWS, SHOWING YOU WHERE TO LOOK FOR INFORMATION CONCERNING SPECIFIC AREAS.
Once again, we urge you to **READ YOUR [CERTIFICATE] [POLICY] CAREFULLY.**

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- Carrier Specific Information

SUPPLEMENTAL BENEFIT RIDERS

INSTRUCTIONS CONCERNING SCHEDULES OF BENEFITS

STANDARD LANGUAGE HAS NOT BEEN DEVELOPED FOR THIS SECTION. CARRIERS MAY INSERT SCHEDULES OF BENEFITS APPROPRIATE FOR EACH STANDARD PLAN. THE FOLLOWING AREAS SHOULD BE ADDRESSED BY ALL CARRIERS. THE STANDARD FORMAT MAY BE MODIFIED ONLY TO:

1. Reflect differences between designs;
2. Address Copayment or Coinsurance limitations and out-of-network differences; and
3. Incorporate benefits provided through Supplemental Benefit Riders.

[INDEMNITY, PPO, POS PLANS]

The following areas should be addressed in the Schedule of Benefits.
Lifetime Maximum Benefit: Indicate that there is no Lifetime Maximum Benefit.

Deductible:

1. Identify the appropriate Single and Family Maximum Deductible amounts, for both in-network and out-of-network services, if applicable.
2. [Explain that the single and Family Deductible amounts, for FFS and PPO in-network may be either:
   - A combined Deductible for both medical and pharmacy services; or
   - A split Deductible with a set amount for medical services and for pharmacy services.]
3. Explain the Family Maximum Deductible for Parent Plus, Member/Spouse, and Family Plans and explain how this Deductible is accumulated.
4. Explain that the Deductible is applied to all Covered Services other than:
   - [Services during confinement at Participating Hospitals (PPO in-network only).]
   - Prenatal care.
   - Immunizations.
   - Well child care.
   - Well adult care.
   - Preventive medical testing.
5. Explain that all covered expenses that apply toward deductible(s), apply equally toward In/Out-Network deductibles regardless of whether the covered expense is In/Out Network.
6. Explain that expenses not applied to the Deductible include:
   - [Copayments.]
   - [Penalties for failure to comply with the Plan Delivery System Rules.]
   - Expenses in excess of the Eligible Expense.
   - Any expense not a Covered Service under the Plan.

Coinsurance:

1. Explain how Coinsurance is calculated and describe the Coinsurance levels appropriate to the respective plan, and for both in-network and out-of network services, if appropriate.
2. Explain that the Covered Person's share of Coinsurance will contribute to satisfaction of the Individual or Family Out-of-Pocket Limit except for:
   - [Penalties for failure to comply with the Plan Delivery System Rules.]
   - Expenses in excess of the Eligible Expense.

- Any expense not a Covered Service under the Plan.

Copayments: Explain how Copayments are applied to Covered Services.

Out-of-Pocket Limit:

1. Explain the appropriate Single or Parent Plus, Member/Spouse, and Family Out-of-Pocket Limit and how this Limit is achieved.
2. Explain how Coinsurance is eliminated when the Out-of-Pocket Limit is reached
3. Explain that expenses which do not apply to the Out-of-Pocket Limit are as follow:

- Coinsurance expenses applied to satisfy the Deductible.
- [Penalties for failure to comply with Plan Delivery System Rules.]
- Expenses in excess of the Eligible Expense.
- Any expense not a Covered Service under the Plan.
- Coinsurance expenses for prescription drugs.

[MANAGED CARE EXCLUSIVE PROVIDER PLANS]

The following areas should be addressed in the Schedule of Benefits.

Plan Year: Indicate Effective Dates

Lifetime Maximum Benefit: Indicate that there is no Lifetime Maximum Benefit

Coinsurance: Explain how Coinsurance is calculated.

Copayments: Explain how copayments are applied to Covered Services.

Out-of-Pocket Limit:

1. Explain the appropriate Single, Parent Plus, Member/Spouse or Family Out-of-Pocket Limit and how this limit is achieved.
2. Explain that the Covered Person's share of Coinsurance and Copayments will contribute to the satisfaction of the Out-of-Pocket Limit except for:
   - Expenses in excess of the Eligible Expense.
   - Any Covered Service to which a Benefit Reduction applies.
   - Copayments for prescription drugs.
   - Any expense not a Covered Service under the Plan.
3. Explain how Copayments and Coinsurance decrease when the limit is met.

FORMAT
Schedule of Benefits

The Schedule of Benefits should address benefits in the following sequence.

DEDUCTIBLE, MAXIMUM OUT OF POCKET, COINSURANCE, LIFETIME MAXIMUM…

INPATIENT HOSPITAL SERVICES…
Inpatient...

EMERGENCY SERVICES…
Hospital Emergency Room…
Urgent Care Services…

OUTPATIENT SERVICES…
Ambulatory/Hospital…
  Outpatient Surgery…
Preventive Services
  Immunizations (Indemnity Plans only)…
  Well Child Care Ages 0-3 (Indemnity Plans only)…
  Well Child Care Ages 4-18 (Indemnity Plans only)…
  Well Adult/Early Detection (Indemnity Plans only)...
Provider Office Visits …
  (Immunizations, Office Diagnostic Testing, Well Child, Well Adult, Allergy Testing)…
Other Outpatient Services…
Diagnostic Tests…

MATERNITY CARE (Prenatal visits, labor and delivery, and postpartum care)…

OTHER SERVICES…
Ambulance….
Prescription Drugs…
Medical Supplies…
DME, and Prosthetic Appliances, and Orthotic Devices...
Hearing Aids and Related Services…
Home Health…
Skilled Nursing/Rehab Facility…

MENTAL HEALTH…
  Inpatient…
  Outpatient…
  Autism spectrum disorders …
SUBSTANCE ABUSE…
  Inpatient…
  Outpatient…

Transplant Coverage …
Hospice …

Physical Therapy…
Occupational Therapy…
Cardiac Rehabilitation Therapy…
Speech Therapy…
Manipulative Treatment…

SCHEDULE OF BENEFITS –
Fee For Services (FFS) AND Preferred Provider Organization (PPO)

BENEFIT	FFS & PPO STANDARD PLAN BENEFITS (Benefit Limits are by Plan Year Regardless of Provider Status)	
	FFS AND PPO IN-NETWORK	PPO OUT-OF-NETWORK
Deductible Maximum Out of Pocket for Covered Expenses After Deductible Coinsurance Lifetime Maximum Benefit	Single $400 Family $800 Single $1500 Family $3000 As Indicated Deductible Applies * Unlimited	Single $700 Family $1400 Single $2500 Family $5000 As Indicated Deductible Applies* Unlimited
Inpatient-Hospital Services - Authorized Semi Private Room and Misc. Services, Intensive/Cardiac/Neonatal	FFS - 15% Coinsurance* PPO - 15% Coinsurance*	35% Coinsurance*
Emergency Services - Hospital Emergency Room (Coinsurance Waived if Admitted)	20% Coinsurance*	20% Coinsurance* (same as in-network)
Urgent Care Services	$25 Copayment	[30% Coinsurance*] [$25 copayment]
Ambulatory/Hospital Outpatient Surgery	20% Coinsurance*	40% Coinsurance*
Preventive Services: Immunizations Well Child Care - Age and Periodicity Limits May Apply Well Adolescent – Age and Periodicity Limits May Apply Well Adult Care - Age and Periodicity Limits May Apply	FFS & PPO No Coinsurance, Copayment or Deductible Per Plan Year Ages 0-3 - Ages 4-18 Office Visits Covered FFS &PPO --No Coinsurance, Copayment or Deductible Routine Physical Exam and Specified Testing FFS & PPO -No Coinsurance, Copayment, or Deductible -	Preventive Services Are Not Covered Out-of-Network
Provider Office Visit	FFS - 20% Coinsurance* PPO - $10 Copayment not subject to Deductible (No Copayment or Co-insurance for Preventive Care)	40% Coinsurance*
Other Outpatient Services	20% Coinsurance*	40% Coinsurance*
Diagnostic Services	20% Coinsurance for services not provided during office visit*	40% Coinsurance*
Maternity Care - Prenatal, Labor, Delivery and Postpartum (Pregnancy of Dependents Covered Same as Spouse Pregnancy)	FFS - 15% Coinsurance* PPO - $10 Copayment for Office Visit in Which Pregnancy is Diagnosed - 15% Coinsurance for Hospitalization (See Bulleted Notes Below)	35% Coinsurance*
Ambulance	20% Coinsurance*	20% Coinsurance*
Prescription Drugs and Contraceptives	20% Coinsurance *- 1 month supply unless mail order available	40% Coinsurance*- 1 month supply unless mail order available
Medical Supplies	20% Coinsurance*	40% Coinsurance*
DME/Prosthetics/Orthotic Devices	20% Coinsurance*	40% Coinsurance*
Hearing Aids and Related Services (children under the age of 18)	One (1) per hearing-impaired ear; every 36 months.	One (1) per hearing-impaired ear; every 36 months.
Home Health Care	100 Visits Per Plan Year Covered in Full*	100 Visits Per Plan Year - 20% Coinsurance*
Skilled Nursing Facility	20% Coinsurance* 30 Days/Plan Year	40% Coinsurance* 30 Days/Plan Year
Mental Health Care Inpatient Outpatient	15% Coinsurance,* 21 days/plan year, 1 admission/6 months (Day Treatment/Intensive Outpatient Can be Substituted for Inpatient Days on a 2 for 1 Basis) 20% Coinsurance*, 20 visits per plan year	40% Coinsurance*, 21 days/plan year, 1 admission/6 month (Day Treatment/Intensive Outpatient Can be Substituted for Inpatient Days on a 2 for 1 Basis) 40% Coinsurance*, 20 visits per plan year

BENEFIT	FFS & PPO STANDARD PLAN BENEFITS (Benefit Limits are by Plan Year Regardless of Provider Status)	
	FFS AND PPO IN-NETWORK	PPO OUT-OF-NETWORK
[Individual and small group ---Autism Spectrum Disorders – $No less than $1,000 Monthly Benefit for Children Ages 1 through 21 Years of Age for Medical care, Pharmacy care, Psychiatric care, Psychological care, Therapeutic care, Applied behavior analysis, and Habilitative and rehabilitative Care] [Large group Autism Spectrum Disorders – no less than $50,000 Annual] Benefit for Children Ages 1 through 6 No less than $1,000 Monthly Benefit for Children Ages7 through 21 Years of Age for Medical care Pharmacy care, Psychiatric care, Psychological care, Therapeutic care, Applied behavior analysis, and Habilitative and rehabilitative Care]	Coinsurance Applicable to Service Provided*	Coinsurance Applicable to Service Provided*
Substance Abuse - Same Inpatient/Outpatient Coverage and Limits as Mental Health	Same Benefit Level as Mental Health	Same Benefit Level as Mental Health
Transplant (Kidney, Cornea, Bone Marrow, Heart, Liver, Lung, Heart/Lung, Pancreas, Small Bowel)	FFS - 15% Coinsurance* PPO - 15% Coinsurance*	35% Coinsurance*
Hospice Care Services	Covered in Full	Covered in Full
Physical Therapy	FFS -- 20% Coinsurance* PPO - $10 Copayment not subject to Deductible 30 visits/Plan Year	40% Coinsurance 30 visits/Plan Year*
Speech Therapy	20% Coinsurance* 30 Visits/Plan Year	40% Coinsurance* 30 Visits/Plan Year
Cardiac Rehabilitation Therapy	20% Coinsurance* 30 visits/Plan Year	40% Coinsurance* 30 visits/Plan Year
Occupational Therapy	FFS --- 20% Coinsurance* PPO - $10 Copayment not subject to Deductible 30 visits/Plan Year	40% Coinsurance* 30 visits/Plan Year
Manipulative Treatment	20% Coinsurance* 30 Visits/Plan Year	40% Coinsurance* 30 Visits/Plan Year

- PPO out-of-network coverage is limited to usual, reasonable and customary charges.
- PPO out-of-network coverage for preventive services is not available.
- PPO out-of-network coverage for transplants, Substance Abuse and mental health care must be prior authorized.
- PPO in-network coverage for maternity care - the initial office visit in which pregnancy is diagnosed is subject to the Provider office visit copayment. No additional Copayments are applied to prenatal visits. All other in-network maternity expenses are subject to the Deductible and Coinsurance except for hospitalization.
- PPO In-Network Deductible does not apply to hospitalization
- Same limits apply whether benefits are in-network or out-of-network, or a combination of both.
- Modalities performed in conjunction with a therapy or manipulative treatment do not constitute a separate visit.

SCHEDULE OF BENEFITS –
Point Of Service (POS) AND Health Maintenance Organization (HMO)

BENEFIT	POS AND HMO STANDARD PLAN BENEFITS (Benefit Limits are by Plan Year Regardless of Provider Status)	
	HMO AND POS IN-NETWORK	POS OUT-OF-NETWORK
Deductible Maximum Out of Pocket for Covered Expenses Coinsurance Lifetime Maximum Benefit	None Single $1500 Family $3000 As Indicated Deductible Applies* Unlimited	Single $700 Family $1400 Single $2500 Family $5000 As Indicated Deductible Applies* Unlimited
Inpatient -Hospital Services - Authorized Semi Private Room and Misc. Services, Intensive/Cardiac/Neonatal	$150 Copayment	30% Coinsurance*
Emergency Services - Hospital Emergency Room (Waived if Admitted)	$50 Copayment	$50 Copayment (same as in-network)
Urgent Care Services	$25 Copayment	[30% Coinsurance*] [$25 copayment]
Ambulatory/Hospital Outpatient Surgery	$75 Copayment	30% Coinsurance*
Provider Office Visit	$10 Copayment (no copayment for Preventive Care)	30% Coinsurance* No Preventive Care Out–of-Network
Other Outpatient Services	$10 Copayment (no copayment for Preventive Care)	30% Coinsurance* No Preventive Care Out–of-Network
Diagnostic Services	$10 Copayment	30% Coinsurance*
Maternity Care - Prenatal, Labor, Delivery and Postpartum (Pregnancy of Dependents Covered Same as Spouse Pregnancy)	$150 Copayment (See Bulleted Notes Below)	30% Coinsurance*
Ambulance	$50 Copayment	$50 Co-Payment
Prescription Drugs and Contraceptives	$10 Copayment - 1 month supply unless mail order available	30% Coinsurance* - 1 month supply unless mail order available
Medical Supplies	$10 Copayment	30% Coinsurance*
DME/Prosthetics/Orthotic Devices	20% Coinsurance	30% Coinsurance*
Hearing Aids (children under the age of 18)	One (1) per hearing-impaired ear; every 36 months.	One (1) per hearing-impaired ear; every 36 months.
Home Health Care	100 Visits Per Plan Year Covered in Full	100 Visits Per Plan Year - 30% Coinsurance*
Skilled Nursing Facility	$150 Copayment 30 Days/Plan Year	30% Coinsurance* 30 Days/Plan Year
Mental Health Care Inpatient Outpatient [Individual and small group ---Autism Spectrum Disorders – No less than $1,000 Monthly Benefit for Children Ages 1 through 21 Years of Age for Medical care, Pharmacy care, Psychiatric care, Psychological care, Therapeutic care, Applied behavior analysis, and Habilitative and rehabilitative Care] [Large group Autism spectrum disorders – no less than $50,000 Annual] Benefit for Children Ages 1 through 6 No less than $1,000 Monthly Benefit for Children Ages7 through 21 Years of Age for Medical care, Pharmacy care, Psychiatric care, Psychological care, Therapeutic care, Applied behavior analysis, and Habilitative and rehabilitative Care]	$150 Copayment, 21 days/Plan Year, 1 admission/6 months (Day Treatment/Intensive Outpatient Can be Substituted for Inpatient Days on a 2 for 1 Basis) $20 Copayment, 20 visits per Plan Year Copayment Applicable to Service Provided	30% Coinsurance 21 days/Plan Year, 1 admission/6 months (Day Treatment/Intensive Outpatient Can be Substituted for Inpatient Days on a 2 for 1 Basis) 30% Coinsurance*, 20 visits per Plan Year Coinsurance Applicable to Service Provided*
Substance Abuse- Same Inpatient/Outpatient Coverage and Limits as Mental Health	Same Benefit Level as Mental Health	Same Benefit Level as Mental Health
Transplant (Kidney, Cornea, Bone Marrow, Heart, Liver, Lung, Heart/Lung, Pancreas, Small Bowel)	$150 Copayment	30% Coinsurance*
Hospice Care Services	Covered in Full	Covered in Full

BENEFIT	POS AND HMO STANDARD PLAN BENEFITS (Benefit Limits are by Plan Year Regardless of Provider Status)	
Physical Therapy	$10 Copayment 30 Visits/Plan Year	30% Coinsurance* 30 Visits/Plan Year
Speech Therapy	$20 Copayment 30 Visits/Plan Year	30% Coinsurance* 30 Visits/Plan Year
Cardiac Rehabilitation Therapy	$20 Copayment 30 Visits/Plan Year	30% Coinsurance* 30 Visits/Plan Year
Occupational Therapy	$10 Copayment 30 Visits/Plan Year	30% Coinsurance* 30 Visits/Plan Year
Manipulative Treatment	$20 Copayment 30 Visits/Plan Year	30% Coinsurance* 30 Visits/Plan Year

- POS out-of-network coverage is limited to usual, reasonable and customary charges.
- POS out-of-network coverage for transplants, Substance Abuse and mental health services is subject to certification.
- POS out-of-network coverage for preventive services is not available.
- HMO POS in-network coverage for maternity care - the initial office visit in which pregnancy is diagnosed is subject to the Provider office visit Copayment. No additional Copayments are applied to prenatal visits.
- Same limits apply whether benefits are in-network or out-of-network, or a combination of both.
- Modalities performed in conjunction with a therapy or manipulative treatment do not constitute a separate visit.

HOW TO USE THIS [CERTIFICATE] [POLICY]

The [Certificate] [Policy] gives the details needed to understand what health care services are covered.

(Group Only) [This Certificate of Coverage is not a legal document. The Plan Document maintained by the group is the legal Contract and this Certificate is subject to its terms and conditions. In the event of conflict, the provisions of the Plan Document will prevail over this Certificate.]

(Individual Only) [This Policy is a legal Contract between the Member and the [Insurance Company] [Health Maintenance Organization].

1. Plan Delivery System Rules

The Plan Delivery System Rules section explains the guidelines for the health care delivery system used by the Plan and the cost containment measures which are designed to help manage the escalating health care cost. Benefits may be denied [or reduced] for failure to follow these provisions.

2. 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, or it is a title.

3. 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] [Policy].

4. Exclusions

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

5. General Provisions

This section tells how coverage works. It describes such things as: who is eligible for coverage and when changes in enrollment may be made; how benefits are paid; how and when coverage terminates; and what privileges exist when coverage terminates.

INSTRUCTIONS CONCERNING
PLAN DELIVERY SYSTEM RULES

STANDARD LANGUAGE HAS NOT BEEN DEVELOPED FOR THIS SECTION. CARRIERS MAY USE THIS SECTION TO EXPLAIN THEIR RESPECTIVE PLAN DELIVERY SYSTEM RULES. CARRIERS MUST BE CAREFUL TO FULLY DESCRIBE ANY RESTRICTIONS, PENALTIES, ETC., IN THE SEQUENCE SHOWN BELOW. CARRIERS SHOULD USE TERMINOLOGY CONSISTENT WITH STANDARD LANGUAGE.

HOW TO USE YOUR PLAN
PLAN DELIVERY SYSTEM RULES

[I. Provider Network and Service Area

- Use Participating Providers for Maximum Benefits
  - Prescription Drugs
  - Mental Health/Substance Abuse
  - Organ Transplants
- Carry Identification (ID) Card at All Times
- Pay Applicable Copayments at Time of Service

II. Role of A Primary Care Physician (PCP)

- Selection and Changing of PCPs
- Referrals for Specialty Care
- Exceptions to Referral Process
- Second Opinions

III. Emergency and Urgent Care Services

  - Out-of-Area Care

IV. Medical Utilization Management

  - Prior Plan Approval (Precertification)

VI. Member Service/Grievance Procedure]

STANDARD DEFINITION LANGUAGE FOLLOWS THESE INSTRUCTIONS. DEFINITION LANGUAGE HAS BEEN BRACKETED TO ALLOW INCLUSION OR EXCLUSION OF DEFINITIONS TO:

1. Explain differences between Managed Care and Indemnity Plans; and
2. Reflect network differences.

No other modifications to definitions are allowed.

Bracketed Language [ ] is Variable Language.

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.

ADVERSE DETERMINATION – A determination by an insurer or its designee that the health care services furnished or proposed to be furnished to a Covered Person are:
1. Not Medically Necessary, as determined by the insurer, or its designee or Experimental or Investigational, as determined by the insurer, or its designee; and
2. Benefit coverage is therefore denied, reduced, or terminated.

Adverse Determination does not mean a determination by an insurer or its designee that the health care services furnished or proposed to be furnished to a Covered Person are specifically limited or excluded in the Covered Person's health benefit plan.

[HEALTH MAINTENANCE ORGANIZATION GROUP CERTIFICATES ONLY]
[**AFFILIATION PERIOD** - A period which, under the terms of coverage offered by a health maintenance organization (HMO), must expire before such coverage becomes effective. The use of an Affiliation Period is in lieu of imposing a Preexisting Condition exclusion period. An Affiliation Period begins on the Member's Enrollment Date, must run concurrently with any Waiting Period imposed by the [Certificate] [Policy], and may not exceed a period of 2 months [(3 months for a Late Enrollee)]. An HMO is not required to provide Covered Services during this period and cannot charge a Premium for coverage during the period.]

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 - 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.

AUTISM SPECTRUM DISORDER - A physical, mental, or cognitive illness or disorder which includes any of the pervasive developmental 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 Developmental disorder Not Otherwise Specified.

[BENEFIT REDUCTION - The amount by which payment for Covered Services will be reduced if the Covered Person fails to comply with the Plan Delivery System Rules.]

CERTIFIED SURGICAL ASSISTANT – A certified surgical assistant or certified first assistant who is certified by the National Surgical Assistant Association on the Certification of Surgical Assistants, the Liaison Council on Certification of Surgical Technologists, or the American Board of Surgical Assistants. The certified surgical assistant is an unlicensed health care Provider who is directly accountable to a Physician licensed under KRS Chapter 311 or, in the absence of a Physician, to a registered nurse licensed under KRS Chapter 314.

[GROUP ONLY]
[CERTIFICATE OF COVERAGE - This document, which lists definitions, benefits, exclusions and other provisions of coverage with the Plan.]

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

CONTRACT - This agreement, any Supplemental Benefit Riders, the Premium Schedule and the application signed by the [Member] [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.]

COVERAGE DENIAL – An insurer’s determination that a service, treatment, drug, or device is specifically limited or excluded under the Covered Person’s health benefit plan.

COVERED PERSON - A person on whose behalf an insurer offering the plan is obligated to pay benefits or provide services under the health insurance policy

COVERED SERVICE - A service or supply that is available under this Plan, when Medically Necessary and obtained in full compliance with all Plan rules. Please refer to the Plan's Health Care Delivery 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 by a Covered Person under any of the following:
a) a group health plan, including church and governmental plans;
b) health insurance coverage;
c) part A or Part B of Title XVIII of the Social Security Act (Medicare);
d) Medicaid, other than coverage consisting solely of benefits under section 1928;
e) the health plan for members of the uniformed services (For example: TRICARE);
f) the Indian Health Service or other tribal organization program;
g) a state health benefits risk pool;
h) a health plan offered under Chapter 89 of Title 5, United States Code, including but not limited to, the Federal Employees Health Benefits Program;
i) a public health plan as defined in federal regulations;
j) a health benefit plan under section 5(e) of the Peace Corps Act;
k) a state Children’s Health Insurance Program; or
l) any other plan which provides comprehensive hospital, medical, and surgical services.

Creditable Coverage does not include any of the following:
a) accident only, including accidental death and dismemberment, coverage, disability income insurance, or any combination thereof;
b) supplemental coverage to liability insurance;
c) liability insurance, including general liability insurance and automobile liability insurance;
d) workers’ compensation or similar insurance;
e) automobile medical payment insurance;
f) credit-only insurance;
g) coverage for on-site medical clinics;
h) benefits if offered separately:

1. limited scope dental and vision;
2. long-term care, nursing home care, home health care, community-based care, or any combination thereof;
3. other similar, limited benefits.

i) benefits if offered as independent, non-coordinated benefits:
1. specified disease or illness coverage; and
2. hospital indemnity or other fixed indemnity insurance;

j) benefits if offered as a separate policy:
1. Medicare Supplement insurance;
2. supplemental coverage to the health plan for active military personnel, including TRICARE; and
3. similar supplemental coverage provided to group health plan coverage; and

k) health flexible spending arrangements.

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. Custodial Care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets 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 the Covered Person before the Plan will provide benefits for all or part of the remaining Covered Services during the Plan Year. Please review the Schedule of Benefits for the method by which the Deductible is calculated.]

DEPENDENT - A person other than the Member, more specifically defined as:

A. The Member's spouse under a legally valid existing marriage;

B. Any children from birth to age 26.

C. For the purpose of determining eligibility for Dependent coverage, the term child or children includes (1) natural children, including newborn children, (2) stepchildren by a legal marriage, (3) children legally placed for adoption, and legally adopted children of the Member, (4) children for whom legal guardianship has been awarded, and (5) children eligible to be claimed as Dependents on the Member's federal income tax return. Also classified as a Dependent child is a child whom the Member or the Member's spouse has a legal obligation under a divorce decree or other court order to provide for the health care expenses of the child.

D. Dependents may only be covered under one health plan sponsored by the Member's group. Unless both parents agree in writing, the parent with custody will be responsible for providing coverage of the dependent children.

E. Eligibility may continue past the age limit for an unmarried child, who has been continuously covered under this [Certificate] [Policy] (or another health plan) since prior to the child reaching the age limit, who is totally disabled and unable to work to support himself due to mental illness or intellectual disability or physical handicap that started before the age limit, and where disability is medically certified by a Physician. The Plan may require proof of such Dependent's disability from time to time. A total disability is defined as the condition that results when any medically determinable physical or mental condition prevents a Dependent from engaging in substantial gainful activity or to be of continuous or indefinite duration and is approved by the Plan.

[DIAGNOSTIC ADMISSION - An admission of an Inpatient that does not require the constant availability of medical supervision or Skilled Nursing Care to monitor a condition. The primary purpose of such admission 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. Diagnostic Services could be provided to an Outpatient to determine the need of treatment.]

DIAGNOSTIC SERVICE - A test or procedure rendered because of specific symptoms and which is directed toward the determination of a definite condition or disease. A Diagnostic Service must be ordered by a Physician or other professional Provider.

DOCTOR OF CHIROPRACTIC – Means one qualified by experience and training and licensed by the Kentucky Board of Chiropractic Examiners to diagnose patients and to treat those patients diagnosed as having diseases or disorders relating to subluxations of the articulations of the human spine and its adjacent tissues by indicated adjustment or manipulations of those subluxations and by applying methods of treatment designed to augment those adjustments or manipulation.

DURABLE MEDICAL EQUIPMENT - Equipment the Plan determines to be: a) designed and able to withstand repeated use; b) used primarily for medical purposes; c) mainly and customarily used to serve a medical purpose; and d) suitable for use in the home.

EFFECTIVE DATE - The date on which coverage for a Covered Person begins.

ELECTIVE ABORTION –An abortion for any reason other than to preserve the life of the female upon whom the abortion is performed.

[INDIVIDUAL ONLY]
ELIGIBLE INDIVIDUAL - An applicant for an individual policy who has eighteen months prior Creditable Coverage, with no break in coverage of more than 63 days, the most recent of which was an employment related group plan sponsored by an employer, church or governmental plan. Certain children are Eligible Individuals, even if they do not have a full 18 months of Creditable Coverage, provided that they were covered under Creditable Coverage within 30 days of birth, adoption, or placement for adoption and have not had a 63 day break in coverage.

ELIGIBLE EXPENSE - A Provider's fee which is the Provider's usual charge for a given service, and 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 and does not exceed the fee schedule developed by the Plan.

EMERGENCY MEDICAL CONDITION - (a) A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson would reasonably have cause to believe constitutes a condition that the absence of immediate medical attention could reasonably be expected to result in:

1. 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;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part; or

(b) With respect to a pregnant woman who is having contractions:

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

[INDIVIDUAL ONLY]
ENROLLMENT DATE - the date an individual files a substantially complete application for coverage which results in the purchase of coverage. The period of time between the filing of the application and the Effective Date is a Waiting Period.

[GROUP ONLY]

ENROLLMENT DATE - the first day of coverage of a Member under this [Certificate][Policy], or if there is a Waiting Period, [and/or an Affiliation Period], the first day of the Waiting Period [and/or the Affiliation Period] (typically the date employment begins).

EXPERIMENTAL OR INVESTIGATIONAL SERVICES - Services or supplies, including treatments, procedures, hospitalizations, drugs, biological products or medical devices, which 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.

Unless otherwise required by law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the United States Food and Drug Administration (FDA), 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 will also 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. Governmental 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 will apply the following five criteria in determining whether services or supplies are Experimental or Investigational:

1.) 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 will 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 Pharmacopeia 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 will 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 will not be considered Experimental or Investigational. In any event, any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental or Investigational.

2.) 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, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;

3.) 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;

4.) 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

5.) Proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph 3, is possible in standard conditions of medical practice, outside clinical investigatory settings.

FAMILY COVERAGE - Coverage for the Member 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] [Policy].]

FREESTANDING RENAL DIALYSIS FACILITY - A Provider other than a Hospital which is primarily engaged in providing renal dialysis treatment, maintenance or training to Outpatients.

GENERIC DRUG – A prescribed therapeutic equivalent (approved by a Government Agency) of a brand name drug that is usually available at a lower cost.

HEARING AID AND RELATED SERVICES – Any wearable, nondisposable instrument or device designed to aid or compensate for impaired human hearing and any parts, attachments, or accessories, including earmolds 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 that 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 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 licensed registered 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.

INTRAOPERATIVE SURGICAL CARE – includes the practice of surgical assisting in which the Certified Surgical Assistant or Physician Assistant is working under the direction of the operating Physician as a first or second assist, and which may include the following procedures:

(a) Positioning the patient;
(b) Preparing and draping the patient for the operative procedure;
(c) Observing the operative site during the operative procedure;
(d) Providing the best possible exposure of the anatomy incident to the operative procedure;
(e) Assisting in closure of incisions and wound dressings; and

(f) Performing any task, within the role of an unlicensed assistive person, or if the assistant is a Physician Assistant, performing any task within the role of a Physician Assistant, as required by the operating Physician incident to the particular procedure being performed.

[GROUP ONLY]
LATE ENROLLEE - An eligible person who requests enrollment in a group health plan after the initial [31] day enrollment period. An individual will not be considered a Late Enrollee if:

a) The person enrolls during his or her initial enrollment period under the group health plan;
b) The person enrolls during a Special Enrollment Period.

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 which 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 a "Member," "Insured," "Subscriber," "Participant," or otherwise.

[MEMBER/SPOUSE COVERAGE - Coverage for the Member and an eligible covered spouse].

MENTAL HEALTH CONDITION - A condition which manifests symptoms which are primarily mental or nervous, regardless of any underlying physical cause. A Mental Health Condition includes, but is not limited to, 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.]

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.

OUT-OF-POCKET LIMIT - A specified amount of expense incurred by a Covered Person for Covered Services in a Plan Year that exceeds the maximum amount of Out-of-Pocket expenditures as specified on the Schedule of Benefits. When the Out-Of-Pocket Limit is reached, Coinsurance and Copayments decrease as specified in the Schedule of Benefits. It does not include any Deductible amounts, any

amounts not paid because a maximum benefit limit has been reached, any Coinsurance or Copayment for prescription drugs, or any amount above an Eligible Expense.

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

[PARENT PLUS COVERAGE - Coverage for the Member and eligible Dependents except the spouse.]

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

PERIOPERATIVE NURSING – A practice of nursing in which the nurse provides preoperative, intraoperative, and postoperative nursing care to surgical patients.

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 - [Carrier Name]

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

PLAN YEAR - Each successive twelve-month period starting on [] and ending on [ ].

[POLICY - This document, which contains definitions, benefits, exclusions and other provisions of coverage with the Plan.]

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] [Policy].

[INDIVIDUAL ONLY]
[PREEXISTING CONDITION - A condition, (mental or physical), which was present and for which medical advice, diagnosis, care or treatment was recommended or received from an individual licensed or similarly authorized to provide such services under state law and operating within the scope of practice authorized under state law, within the 6 month period ending on the Enrollment Date. Pregnancy is [not] considered a Preexisting Condition. Domestic violence is not considered a Preexisting Condition. Genetic information will not be used as a condition in the absence of a diagnosis. Preexisting Conditions do not apply to Eligible Individuals.]

[GROUP ONLY]
[PREEXISTING CONDITION - A condition, (mental or physical), which was present and for which medical advice, diagnosis, care or treatment was recommended or received from an individual licensed or similarly authorized to provide such services under state law and operating within the scope of practice authorized under state law, within the 6 month period ending on the Enrollment Date. Pregnancy is not considered a Preexisting Condition. Domestic violence is not considered a Preexisting Condition. Genetic information will not be used as a condition in the absence of a diagnosis.]

[PRIMARY CARE PHYSICIAN - A [Network] [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; initiates a Covered Person's referral for specialist services; and is responsible for maintaining continuity of patient care.]

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

PROVIDER - A facility or person, including a Hospital or Physician, 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:

Advance Practice Registered Nurse
Ambulatory Surgical Center
Autism Services Provider
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 Assistant Behavior Analyst
Licensed Behavior Analyst
Licensed Clinical Social Worker
Licensed Marriage and Family Therapist
Licensed Occupational Therapist
Licensed Pharmacist
Licensed Physical Therapist
Licensed Practical Nurse
Licensed Psychologist
Licensed Psychological Associate
Licensed Psychological Practitioner
Licensed Speech Pathologist
Licensed Speech Therapist
Nursing Facility
Ophthalmic Dispenser
Physician Assistant
Psychiatric Facility
Registered Nurse
Respiratory Therapist
Substance Abuse Treatment Facility

PSYCHIATRIC FACILITY - A Provider primarily engaged in providing diagnostic and therapeutic services for the treatment of Mental Health Conditions. The facility must be operated in accordance with the laws of the jurisdiction in which it is located and provide treatment by or under the care of Physicians and Nursing Services whenever the patient is in the facility.

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 (1) 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 (2) 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.

SERIOUS MENTAL CONDITION or SIGNIFICANT BEHAVIORAL PROBLEM –A condition:
(a) Identified by a diagnostic code from the most recent edition of the:
  1. International Classification of Diseases-Clinical Modification, including only diagnosis codes ranging from 290 through 299.9, 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 Center 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 Center.

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

SERIOUS PHYSICAL CONDITION –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 Center.

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

[**SERVICE AREA** - The geographic area in which the Plan is authorized to operate.]

SINGLE COVERAGE - Coverage for the Member only.

SKILLED NURSING CARE - Care needed for medical conditions which require care by skilled medical personnel such as registered nurses or professional therapists. Care is available 24 hours per day, if ordered by a physician, and usually involves a treatment plan.

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.

[GROUP ONLY]
SPECIAL ENROLLMENT PERIOD - A period of time during which an eligible person or Dependent who loses other coverage or incurs a change in his or her family status may enroll in the Plan without being considered a Late Enrollee.

SUBSTANCE ABUSE - This term includes: (1) alcoholism; or (2) dependence, addiction or abuse of: (a) alcohol; (b) chemicals; or (c) 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.

SUPPLEMENTAL HEALTH BENEFIT RIDERS - Approved riders which may be offered to enhance benefits under the approved standard plan. These riders may not duplicate benefits paid under this Plan.

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 illness or Accidental Injury to promote the recovery of the patient. Therapy Services include but are not limited to:

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. Respiratory Therapy - Introduction of dry or moist gases into the lungs for treatment purposes.
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, have had heart surgery, or have other cardiac problems.
E. 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.

[URGENT CARE - Medical care which is appropriate to the treatment of an illness or injury that is not a life-threatening emergency, but requires prompt medical attention. Urgent Care includes the treatment of minor injuries as a result of accidents, the relief or elimination of severe pain, or the moderation of an acute illness.]

[**GROUP ONLY]**
WAITING PERIOD - The period of time that begins when an individual becomes eligible for coverage and ends on the Effective Date of coverage under the Plan.

[INDIVIDUAL ONLY]
WAITING PERIOD - The period of time that begins on the date the individual submits a substantially complete application and ends on the Effective Date of coverage.

INSTRUCTIONS CONCERNING BENEFITS

STANDARD BENEFIT LANGUAGE FOLLOWS THESE INSTRUCTIONS. BENEFITS LANGUAGE HAS BEEN BRACKETED TO ALLOW INCLUSION OR EXCLUSION OF BENEFIT LANGUAGE TO:

1. Explain differences between Managed Care and Fee for Service Plans; and
2. Reflect network differences.

MODIFICATIONS TO THIS LANGUAGE ARE PROHIBITED EXCEPT TO:

1. Indicate where appropriate that the Covered Person should refer to the Plan Delivery System Rules for information concerning restrictions on Covered Services.
2. Indicate that the Covered Person should refer to the Schedule of Benefits concerning limitations on Covered Services.

NO OTHER MODIFICATIONS TO BENEFITS LANGUAGE ARE ALLOWED.

Bracketed [ ] material is variable and can be included or excluded to accommodate the nature of the Plan.

Subject to the applicable Exclusions, limitations, Delivery System Rules, Medical Utilization Review Provisions, and other conditions of the Plan, Covered Persons are entitled to the benefits in this Benefits Section for Covered Services. Covered Services must be rendered by a Hospital, Physician or other Provider during each Plan Year. Benefits only will 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. Benefit Reductions may apply for failure to follow Medical Utilization Review Provisions.

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

(FOR USE BY PLANS WHICH INCLUDE A WAITING PERIOD FOR PRE-EXISTING CONDITIONS)

[GROUP ONLY]
[Preexisting Conditions for which medical care, diagnosis or treatment was recommended or received from an individual licensed or similarly authorized to provide such services under state law and operating within the scope of practice authorized under state law, within the [insert a number not to exceed six (6)] month period ending on the Enrollment Date are not covered under this [Certificate][Policy] for a period of [insert a number not to exceed 12] months [or [insert a number not to exceed 18] months for a Late Enrollee]. However, the Plan will credit the time the Covered Person was covered under other Creditable Coverage if the coverage was continuous to a date not more than 63 days prior to the Enrollment Date of this Plan. Waiting Periods [and Affiliation Periods] are not considered a break in coverage. The exclusion period for coverage of a Pre-existing Condition does not apply to pregnancy, genetic information in the absence of a diagnosis, domestic violence, or children under the age of 19.]

[INDIVIDUAL ONLY]
[Preexisting Conditions for which medical care, diagnosis or treatment was recommended or received from an individual licensed or similarly authorized to provide such services under state law and operating within the scope of practice authorized under state law, within the [insert a number not to exceed six (6)] month period ending on the Enrollment Date are not covered under this Policy for a period of [insert a number not to exceed 12] months, However, the Plan will credit the time the Covered Person was covered under other Creditable Coverage if the coverage was continuous to a date not more than 63 days prior to the Enrollment Date of this Plan and if the Creditable Coverage provided benefits substantially similar to the benefits of this Plan. The period of time between the Enrollment Date and the Effective Date is a Waiting Period and is not considered a break in coverage. The exclusion period for coverage of a Pre-existing Condition does not apply to genetic information in the absence of a diagnosis, domestic violence, children under the age of 19, or to Eligible Individuals.]

(FOR USE BY GROUP AND INDIVIDUAL PLANS WHICH DO NOT INCLUDE A WAITING PERIOD FOR PRE-EXISTING CONDITIONS)
[This [Certificate] [Policy] does not delay coverage for Preexisting Conditions.]

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

1. INPATIENT HOSPITAL SERVICES
   A. Room and Board when the Covered Person occupies:

      i. A room with two or more beds, known as a semi-private room or ward; or

ii.. A private room. The private room allowances shall be limited to an amount equal to the Hospital's average semi-private rate. In cases of a facility which only has private rooms, then the average semi-private rate does not apply; or

iii. 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 pre-certification approval by the Plan; or

iv. 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:

i. Use of operating, delivery, and treatment rooms and equipment;

ii. Prescription drugs administered to an Inpatient;

iii. Administration of blood and blood processing;

iv. Anesthesia, anesthesia supplies and services rendered by an employee of the Hospital or through approved contractual arrangements;

v. Medical and surgical dressings, supplies, casts, and splints;

vi. Diagnostic Services;

vii. Therapy Services; and

viii. Special Care Unit Nursing services, other than the portion payable under 1(A)(iv) above.

C. Medical Care To Inpatients--Medical care for conditions not related to Maternity Care or Mental Health Conditions, except as specifically provided. Benefits for medical care to Inpatients are limited to:

i. Visits by the attending Physician.

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

iii. Concurrent medical care

a. Medical care in addition to surgery during the same admission for unrelated medical conditions. This medical care is provided by a Physician other than the operating surgeon.

b. 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.

iv. 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.

2. EMERGENCY SERVICES

Benefits are provided for treatment of Emergency Medical Conditions and emergency screening and stabilization services without prior authorization 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 for emergency services include facility costs, Physician services, supplies, and prescriptions.

Services in Hospital emergency rooms is subject to the emergency room [Copayment] [Coinsurance] on the Schedule of Benefits. The [Copayment] [Coinsurance] will not be

required if the Covered Person is admitted, within 24 hours, as an Inpatient for the condition for which he or she sought emergency services.

[If a Covered Person is admitted to a Hospital for emergency services outside of the Service Area, the Plan may require that the Covered Person be transferred to a Participating Hospital as soon as medically feasible.]

Benefits are not provided for the use of an emergency room except for treatment of Emergency Medical Conditions, emergency screening and stabilization. All follow-up or continued care, services or prescriptions, must be authorized [by your Primary Care Physician].

3. URGENT CARE SERVICES

Benefits are provided for Urgent Care at a freestanding or Hospital based Urgent Care facility when the Covered Person is outside the Service Area or when the Primary Care Physician is unavailable and 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 care for (but is not limited to) 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's Delivery System Rules.

4. OUTPATIENT HOSPITAL/AMBULATORY SURGICAL CENTER FACILITY/ OTHER PROVIDER SERVICES

i. 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.

ii. Ancillary services listed below and furnished to an Outpatient [, if pre-authorized by [the Plan][the Primary Care Physician]]:

a. Use of operating room and recovery rooms;
b. Respiratory therapy (e.g. oxygen);
c. Administered drugs and medicine;
d. Intravenous solutions;
e. Dressings, including ordinary casts, splints or trusses;
f. Anesthetics and their administration;
g. Transfusion supplies and equipment; and
h. Diagnostic Services, including radiology, ultrasound, laboratory, pathology and approved machine testing [e.g. electrocardiogram (EKG)].

5. SURGICAL SERVICES

A. Surgery

When performed by a covered licensed Provider, coverage includes 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 Provider other than the surgeon or assistant surgeon, for administration of anesthesia, as ordered by the attending Physician.

D. Voluntary Sterilization

Regardless of Medical Necessity, coverage is provided for Outpatient procedures performed for the sole purpose of voluntary sterilization. No coverage is provided for reversal or any attempted reversal of a previously performed sterilization.

E. Reconstructive Surgery

Services, supplies or care incurred for reconstructive surgery: (a) when such surgery is incidental to or follows surgery resulting from injury or illness of the involved part; (b) because of congenital disease or anomaly of a Member which has resulted in a functional defect (difficulty in activities of daily living); (c) all stages of breast reconstruction surgery and correction of breast size disproportion or dissymmetry following a mastectomy that resulted from breast cancer; or (d) treatment of lymphedemas following a mastectomy.

F. Cochlear Implants

6. SECOND OPINION

The Plan can require a Covered Person to obtain a second opinion evaluation for elective surgical procedures or medical treatment proposed to be performed on an Inpatient Hospital basis. Elective surgery or medical treatment is defined as covered procedures which may be safely deferred and does not involve an Emergency Medical Condition. A second opinion is not required for surgery or medical treatment performed in a Physician's office.

If the Plan requires a second opinion evaluation, they may also specify from whom the second opinion must be obtained, and the Physician must also be qualified to perform the surgery or medical treatment involved. The second opinion Physician cannot be a part of the same professional office practice as the Physician who provided the original recommendation for the procedure. Distance may not be a factor in determining the necessity of required second opinion evaluations.

If the Plan requires a Covered Person to obtain a second opinion prior to the recommended procedure, the Plan will cover the second opinion in full. The Covered Services will include the consulting Physician's second opinion consultation, and any directly related Diagnostic Services required by the Plan to be performed to confirm the need for the procedure as first recommended.

When a Covered Person obtains a second opinion evaluation not required by the Plan, such evaluation must be obtained within the procedures specified in the Plan's Delivery System Rules for coverage to apply.

7. OUTPATIENT/PROVIDER OFFICE SERVICES

A. Preventive Services

Well child periodic examinations, developmental assessments and anticipatory guidance necessary to monitor the normal growth and development of a child;

Adult physical exams;

Periodic early detection services, including cervical pap smears, mammography, bone density testing for women age 35 and older, cardiac risk profile (blood test), prostate-specific antigen (PSA), serum glucose, and E.K.G.. All colorectal cancer examinations and laboratory tests specified in current American Cancer Society guidelines for colorectal cancer screening; Allergy testing; Diabetes self-management training and education, including nutrition therapy; and Contraceptive services provided in the office of a qualified Provider.

Immunizations are covered in accordance with recommendations of the Advisory Council on Immunization Practices of the Centers for Disease Control and Prevention.

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

B. Provider Office Visit

Office visits for medical care and consultations to examine, diagnose, and treat an illness or injury performed in the Provider's office. Office visits also include injections, serum and allergy testing. If an allergy injection or allergy serum is the only charge from a network provider's office, no Copayment or Coinsurance amount is required. Allergy testing is subject to a separate Copayment/Coinsurance as applicable.

Diagnostic Services when required to diagnose or monitor a symptom, disease or condition when performed in conjunction with or during the Provider office visit.

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

C. Outpatient Services

Non-surgical, medical care services rendered by a qualified Provider to a Covered Person, for the examination, diagnosis, and treatment of a covered illness or injury and/or for the purposes of preventive care, including patient education, except as excluded by the Plan.

Medical care which 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 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.

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

Minor surgery and surgical services including local anesthesia, sedation and supplies. The surgical fee includes normal post-operative care when performed in the Provider's office.

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

8. DIAGNOSTIC SERVICES

Diagnostic Services, including their interpretation, for the treatment of an illness or injury, may include but are not limited to:

A. x-ray and other radiology/imaging services, including mammograms for any person diagnosed with breast disease,
B. laboratory and pathology services, and
C. cardiographic, encephalographic, and radioisotope tests.

9. MATERNITY CARE

Coverage is provided for treatment of an Inpatient and Outpatient for prenatal visits, delivery, and postpartum care provided to the Member and Dependent. Coverage is provided for services provided to the newborn of a Member or Dependent.

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 or Dependent as defined in the eligibility section. Coverage includes, but is not limited to, the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, 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 Cesarean 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.

(Indemnity/FFS only) [Coinsurance per service or office visit is applicable for all Maternity Care Covered Services.]
(PPO only) [When prenatal care is furnished by Participating Providers, no Copayments will be charged for prenatal visits. Coinsurance per service or office visit is applicable for all prenatal care rendered by Non-Participating Providers. Coinsurance per service for all other Maternity Care Covered Services is applicable, whether provided by Participating or Non-Participating Providers.]
(HMO only) [A single Copayment per admission is applicable for all Maternity Care Covered Services.]
(POS only) [When Maternity Care Covered Services are furnished by Participating Providers, a single Copayment per admission is applicable for all Maternity Care Covered Services. Coinsurance per service or office visit is applicable for all Maternity Care Covered Services rendered by Non-Participating Providers [or by Participating Providers without a referral.]]

10. AMBULANCE SERVICES

A. Ambulance service providing local transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured:

   i. from a Covered Person's home or scene of accident or medical emergency to the nearest 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 nearest facility outside the local area that can provide the necessary services;

ii. between Hospitals; and

iii. between a Hospital and Nursing Facility, with prior approval of 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:

i. from a Hospital to the Covered Person's home, or

ii. from a Nursing Facility to the Covered Person's home when the transportation to the facility would qualify as a Covered Service.
Benefits are limited to services involving admissions for Inpatients or treatment of an Outpatient for Emergency Care.

C. Air Ambulance. Air ambulance services are a covered benefit only when Medically Necessary, except when ordered by a fire or public safety official, or when the Member is not in a position to refuse. Air ambulance trips must be made to the nearest facility that can give Covered Services appropriate for the Member's condition. 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.

11. 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 must occur within seventy-two (72) hours of the accident. Definitive treatment services must 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 Plan 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. Accident-related dental services must be authorized in advance by the Plan.

For the purpose of this benefit, Accident-related Dental Services are services performed by a Doctor of Dental Surgery (D.D.S.) or Doctor of Medical Dentistry.

B. Anesthesia and Facility Benefit:

Coverage is provided for general anesthesia and Hospital or Ambulatory Surgical Center 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.

12. PRESCRIPTION DRUGS AND CONTRACEPTIVES

Except for the treatment of inherited metabolic diseases, prescription drug coverage is limited to injectable insulin, syringes, blood glucose and urine reagent test strips, contraceptives, 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.

Benefits for covered prescription drugs are limited to quantities which can reasonably be expected to be consumed or used within one month, or as otherwise authorized by the Plan.

Refer to your Plan's Delivery System Rules regarding generic drugs [and any use of formularies and mail order programs]. If a Covered Person specifically requests a brand name drug, the Covered Person shall be responsible for any difference between the brand name drug and the Generic Drug.

Refer to your Plan's Delivery System Rules regarding the refill exceptions and override policy.

13. 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 Durable Medical Equipment. These supplies are disposable, non-reusable, and are not helpful in the absence of an illness or injury. Common household items are not considered medical supplies.

Medical supplies used in the direct administration of a Covered Service by a Provider are covered, including but not limited to supplies for insulin pumps, ostomy care, tracheotomy care, wound care, and supplies for urinary catheterization.

14. DURABLE MEDICAL EQUIPMENT

Coverage for Durable Medical Equipment includes, but is not limited to, insulin pumps, apnea monitors, breathing equipment, hospital-type beds, walkers, crutches and wheelchairs. Durable Medical Equipment is limited to the rental (but not to exceed the total cost of purchase) or, at the option of the Plan, the purchase of Durable Medical Equipment [prescribed by a Covered Person's attending Physician] for therapeutic use. The rental/purchase includes the necessary fittings, adjustments, and delivery/installation of the Durable Medical Equipment. Coverage is also provided for necessary repairs to keep such equipment serviceable. Replacement coverage for previous Durable Medical Equipment may only be considered when the equipment to be replaced can no longer be made serviceable. No coverage will be considered for replacement of Durable Medical Equipment which is lost or stolen. No coverage for replacement or repair will be considered if equipment is broken by abuse or lack of maintenance.

Items that are not considered Durable Medical Equipment include, but are not limited to: adjustments made to vehicles, air conditioners, air purifiers, 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.

15. PROSTHETIC APPLIANCES/ORTHOTIC DEVICES

Coverage for the purchase, fitting, necessary adjustments, repairs, and replacements of prosthetic and orthotic devices and supplies which replace all or part of an absent body part (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning body part. Dental appliances other than those required in treatment of TMJ or CMJ are excluded. The replacement of implanted cataract lenses is excluded except when new cataract lenses are needed because of Medical Necessity.

16. HEARING AID AND RELATED SERVICES

Coverage for the full cost of one (1) hearing aid per hearing impaired ear every thirty-six (36) months for Hearing Aids and all Related Services for insured individuals under eighteen (18) years of age. The Hearing Aid and all Related Services must be prescribed by a licensed 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, that maximum benefit will be provided toward the purchase of the more expensive hearing aid.

17. HOME HEALTH CARE

Home Health Care Services as necessary to avoid or reduce hospitalization of a Covered Person. Services must be preauthorized by the Plan and may include the provision of intermittent Skilled Nursing Care; intermittent physical therapy, occupational therapy and speech therapy; part-time or intermittent home health aide services under the supervision of a registered nurse; and medical supplies, laboratory services and intravenous drug therapy administered during a home health visit. These therapies, when received from a Home Health Agency, do not count toward a Member's Plan Year benefit maximum for Therapy Services. A visit of at least four () hours by a home health aide service is considered one Home Health Care visit.

The Plan will not pay for services not authorized, not included in the Physician's prescribed treatment plan, or services provided by an immediate family member, or Custodial Care.

18. SKILLED NURSING FACILITY SERVICES

Room and board (including special diets) 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.

19. MENTAL HEALTH SERVICES

Covered services 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 preauthorization and periodic review, as determined by the Plan.

A. Inpatient Services
Inpatient Hospital or Psychiatric Facility Services for the treatment of Mental Health Conditions. Benefits are also provided for:
   i. Individual Psychotherapy Treatment;
   ii. Group Psychotherapy Treatment;
   iii. Psychological Testing; and
   iv. Convulsive Therapy Treatment.

Electroconvulsive therapy or drug treatment of convulsive disorders, including anesthesia when administered concurrently with the treatment by the same professional Provider. If anesthesia is administered by a different licensed Provider, 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 days of treatment in a Day Treatment Program or Intensive Outpatient Program are the equivalent of one day as an Inpatient.

C. Outpatient Services

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.

AUTISM SPECTRUM DISORDER- Benefits are provided for Pharmacy care, Psychiatric care, Psychological care, Therapeutic care, Applied Behavior Analysis, Habilitative and rehabilitative care for a Covered Person age 1 through 21 for the treatment of Autism spectrum disorders. The maximum dollar limit for this benefit shall not apply to other health or mental health conditions of the Covered Person which are not related to the treatment of Autism Spectrum Disorders.
The following definitions only apply to the Autism Spectrum Disorder Benefit:

"Applied behavior analysis" means 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;

"Autism services provider" means any licensed person, entity, or group that provides treatment of autism spectrum disorders.

"Diagnosis of autism spectrum disorders" means medically necessary assessments, evaluations, or tests to diagnose whether an individual has any of the autism spectrum disorders, including testing tools which shall be appropriate to the presenting characteristics and age of the individual and be empirically validated for autism spectrum disorders to provide evidence that meets the criteria for autism spectrum disorder in the most recent diagnostic and statistical Manual of Mental Disorders published by the American Psychiatric Association;

"Habilitative or rehabilitative care" means professional counseling and guidance services, therapy, and treatment programs, including applied behavior analysis, that are necessary to develop, maintain, and restore, to the maximum extent practicable, the functioning of an individual;

“Medical care" means services provided by a licensed physician, an advanced registered nurse practitioner, or other licensed health care provider;

"Pharmacy care" means medically necessary medications prescribed by a licensed physician or other health-care practitioner with prescribing authority, if covered by the plan, and any medically necessary health-related services to determine the need or effectiveness of the medications;

"Psychiatric care" means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices;

"Psychological care" means direct or consultative services provided by an individual licensed by the Kentucky Board of Examiners of Psychology or by the appropriate licensing agency in the state in which the individual practices;
"Therapeutic care" means services provided by licensed speech therapists, occupational therapists, or physical therapists; and

"Treatment for autism spectrum disorders" includes the following care for an individual diagnosed with any of the autism spectrum disorders:
(a) Medical care;
(b) Habilitative or rehabilitative care;
(c) Pharmacy care, if covered by the plan;
(d) Psychiatric care;
(e) Psychological care;
(f) Therapeutic care; and

(g) Applied behavior analysis prescribed or ordered by a licensed health or allied health professional.

20. SUBSTANCE ABUSE

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 preauthorization and periodic review as established by the Plan.

A. Inpatient Services

Services rendered to an Inpatient by a Hospital or Substance Abuse Treatment Facility for the treatment of Substance Abuse. Services to an Inpatient will be authorized only when deemed the least restrictive mode of treatment. Benefits are also provided for:

i. Individual Treatment;
ii. Group Treatment; and
iii. Testing.

B. Day Treatment/Intensive Outpatient Programs

The treatment of Substance Abuse in a day treatment or 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 days of treatment in a Day Treatment or Intensive Outpatient Program are the equivalent of one day as an Inpatient.

C. Outpatient Services

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 and group treatment and testing.

21. HUMAN ORGAN AND TISSUE TRANSPLANTS

Benefits for human organ or tissue transplants are limited to kidney, cornea, certain bone marrow, heart, liver, lung, heart/lung, small bowel and pancreas transplants. The Plan does not provide benefits for procedures which are not Medically Necessary or Experimental or Investigational Services.

To be eligible to receive benefits, the Covered Person must use a participating facility and/or Provider approved by the Plan which is (are) qualified to perform the above transplant procedures and comply with the medical utilization management provisions. No benefits will be paid for charges for the transplant if the procedure was not authorized prior to the pre-testing, evaluation and donor search.

Benefits for liver transplants are provided for primary biliary cirrhosis, primary sclerosing cholangitis, postnecrotic cirrhosis hepatitis B surface antigen negative, alcoholic cirrhosis (only if 6 months abstinence from alcohol is documented), alpha-1 antitrypsin deficiency disease, Wilson's disease, primary hemochromatosis, biliary atresia, inborn errors of metabolism that are life threatening (tyrosinemia, oxalosis, glycogen storage diseases, etc.), protoporphyria, Byler’s disease, non-alcoholic steatohepatitis, diseases caused by external agents, including trauma, chronic viral hepatitis due to hepatitis A, B, or C, cryptogenic cirrhosis, toxic reactions, Budd-

Chiari syndrome, Alagill's syndrome, amyloidosis, polycystic disease and familial amyloid polyneuropathy.

Benefits for liver transplants will also be provided for primary hepatic carcinoma. For this condition, liver transplant is covered only if the cancer does not extend beyond the margins of the liver. Benefits are not provided for liver transplant for cholangiocarcinoma or metastatic carcinomas. For the purposes of this section, metastatic refers to cancer cells transmitted to the liver from an original site elsewhere in the body.

Benefits are provided for Medically Necessary adult-to-adult right lobe living donor liver transplant. Benefits are not provided for adult-to-adult left lobe living donor liver transplant.

Benefits are provided for heart transplants that are Medically Necessary and not Experimental or Investigational Services.

If high dose chemotherapy with autologous bone marrow transplantation or stem cell transplantation are Medically Necessary and indicated for treatment of breast cancer, benefits for the autologous bone marrow transplantation or stem cell transplantation are provided. Benefits for bone marrow (allogeneic, autologous and peripheral blood stem cells and cord blood) transplants are also provided for the following conditions, if Medically Necessary:

Disease	
Acute Lymphocytic Leukemia	covered
Acute Myelogenous Leukemia	covered
Chronic Myelogenous Leukemia	covered
Primitive Neuroectodermal Tumors	covered
Pediatric Neuroblastoma	covered
Recurrent Ewing's Sarcoma	covered
Germ Cell Tumors	covered
Multiple Myeloma	covered
Hodgkin's Lymphoma	covered
Non-Hodgkin's Lymphoma	covered
Myelodysplastic Diseases	covered
Aplastic Anemia	covered
Wiskott-Aldrich Syndrome	covered
Severe Combined Immunodeficiency Disorder	covered
Albert-Schoenberg Syndrome	covered
Homozygous Beta-thalassemia	covered

Benefits for bone marrow (allogeneic, autologous and peripheral blood stem cells and cord blood) transplants are not provided for any tandem procedures unless specifically identified herein, or for the following conditions:

Chronic Lymphocytic Leukemia	not covered
Small Cell Lymphocytic Leukmia	not covered
Epithelial Ovarian Cancer	not covered
Malignant Astrocytomas and Glioma	not covered
Ependymoma	not covered

Unless specifically named in this Certificate, benefits are not covered for bone marrow transplants (allogeneic, autologous or peripheral blood stem cells) for treatment of myeloproliferative diseases other than those explicitly named above, cancers or diseases of the brain, bone, large bowel, small bowel, esophagus, kidney, liver, lungs, pharynx, prostate, skin, connective tissue and uterus.

As used in this document, the term "bone marrow transplant" means the transplant of human blood precursor cells which are administered to a patient following ablative or myelosuppressive therapy. Such cells may be derived from bone marrow, circulating blood obtained from the patient in an autologous transplant or from a matched related or unrelated donor. If chemotherapy is an integral part of the treatment involving bone marrow transplantation, the term "bone marrow transplant" includes the harvesting, transplantation, and chemotherapy components.

Benefits are provided for lung transplants that are Medically Necessary and not Experimental or Investigational Services.

Benefits are provided for heart/lung transplants that are Medically Necessary and not Experimental or Investigational Services.

[Lobar lung replacement is covered for irreversible, end-stage pulmonary disease if excised lobe is sized appropriately for the recipient's thoracic dimensions.]

Benefits for pancreas transplants will be provided only if performed simultaneously with or following a kidney transplant or for life threatening severe hypoglycemic unawareness.

[The Plan may amend the above Covered Transplant Procedure list to include additional diagnoses when published peer-reviewed studies establish that transplantation has a positive long-term outcome.]

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.

i. When the transplant recipient and donor are both Covered Persons under this Plan, benefits will be provided for both under each individual's available coverage.

ii. When only the transplant recipient is eligible under this Plan, 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.

iii. When the transplant recipient is not eligible under this plan, and the donor is, the donor will receive his or her Plan benefits for surgical and necessary medical care 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

i. 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.

ii. Eligible Expenses also include charges which are directly related to the surgical, storage, and transportation costs incurred in the donation of an organ for a covered transplant procedure. Eligible Expenses exclude any expenses incurred by a living donor for transportation, meals, or lodging.

iii. In order to pre-authorize the transplant procedure itself, the Plan must be given the opportunity to review the clinical results of the evaluation. Approval will be based on written criteria and procedures established or adopted by the Plan.

iv. Reasonable and necessary transportation if the transplant is to be performed more than 75 miles from patient's home. Meals and lodging expenses are covered to and from the site of the Covered Transplant procedure and while at the site of the Covered Transplant Procedure for the Member and a companion within reasonable limits determined by the Plan. If the patient is a minor, expenses for transportation, meals and lodging will be covered for two companions.

C. Non-Eligible Expenses

i. No benefits will be paid unless your coverage is in effect on the date the covered procedure is performed.

ii. In addition to the Exclusions applicable under the Plan, 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.

iii. 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 Plan.

iv. Any human organ or tissue transplant not specifically listed in this Certificate.

22. 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 months or less and elects Hospice coverage in lieu of continued attempts at cure.

Hospice includes services, supplies and care to help provide comfort and relief from pain.

All services must be precertified by the Plan. 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 including Respite Care, home health aides and homemaker services, physical therapy, occupational therapy and speech/language pathology services, and counseling, including dietary counseling.

23. THERAPY SERVICES

The treatment of an acute condition, by manual or physical means, including therapy not resulting in hospitalization, shall be presumed to become maintenance care and not a Covered Service after

the number of visits specified in the benefits schedule. Physical, occupational, Outpatient cardiac rehabilitation, and speech Therapy Services received from a Home Health Agency are considered Home Health Care services. These do not count towards the Member's Plan Year Therapy Services maximum benefit limit.

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. Speech Therapy

The treatment rendered to restore speech loss due to illness or Accidental Injury.

C. Cardiac Rehabilitation

To receive cardiac rehabilitation as an Outpatient, a Covered Person must have suffered a heart attack or incurred cardiac bypass surgery during the 12 month period prior to receiving cardiac rehabilitation to be eligible for benefits. To be entitled to cardiac rehabilitation as an Inpatient, a Covered Person must not be admitted to a Hospital solely for the purpose of receiving cardiac rehabilitation.

D. Occupational Therapy

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

24. MANIPULATIVE TREATMENT

This treatment is performed to correct by manual or mechanical means structural imbalance or subluxation to remove nerve interference from or related to distortion, misalignment or subluxation of or in the vertebral column. Manipulative treatments whether performed and billed as the only procedure or manipulative treatments performed in conjunction with an exam and billed as an office visit will be counted toward any maximum for manipulative treatments as specified in the Schedule of Benefits.

25. 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 [provided the charges are for services included in a treatment plan authorized by the Plan prior to the surgery]. TMJ or CMJ disorder is a jaw/joint disorder which 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 esthetic condition shall be covered surgical procedures.

Covered Services for nonsurgical diagnosis and treatment of TMJ or CMJ dysfunction or disorder or craniomandibular jaw disorders are limited to: (a) diagnostic examination; (b) diagnostic studies; (c) injection of muscle relaxants; (d) therapeutic drug injections; (e) physical therapy; (f)

diathermy therapy; (g) ultrasound therapy; (h) splint therapy; and (i) arthrocentesis and aspiration. Benefits are not provided for charges for anything not listed above, including but not limited to; (a) any appliance or the adjustment of any appliance involving orthodontics; (b) any electronic diagnostic modalities; (c) occlusal analysis; and (d) muscle testing.

26. MEDICAL/DISEASE CASE MANAGEMENT

Plans may extend coverage of Covered Services or offer benefits in non-covered areas under a medical case management program, if to do so would be a medically appropriate, cost effective alternative. The Plan and the Provider must be in agreement on the treatment and the patient fully informed of options and consequences of the decision. The Provider is required to furnish a plan of treatment for the patient, which must be approved by the Plan as part of the determination of the patient's eligibility for medical case management. The Provider must also keep the Plan informed of the patient's progress and prognosis on an ongoing basis.

27. INBORN ERRORS OF METABOLISM OR GENETIC CONDITIONS

Benefits are provided for therapeutic food, formulas, supplements, and low-protein modified food products for the treatment of inborn errors of metabolism or genetic conditions if these products are obtained for the therapeutic treatment of inborn errors of metabolism or genetic conditions and are administered under the direction of a physician. Coverage for therapeutic food, formulas, and supplements shall be subject, for each Plan Year, to a cap of twenty five thousand dollars ($25,000), and low-protein modified foods shall be subject, for each Plan Year, to a cap of four thousand dollars ($4,000). These caps are subject to annual inflation adjustments based on the consumer price index.

Examples of inborn errors of metabolism include but are not limited to the following conditions: 1) Phenylketonuria; 2) Hyperphenylalaninemia; 3) Tyrosinemia (types I, II, and III); 4) Maple syrup urine disease; 5) A-ketoacid dehydrogenase deficiency; 6) Isovaleryl-CoA dehydrogenase deficiency; 7) 3-methylcrotonyl-CoA carbaoxylase deficiency; 8) 3-methylglutaconyl-CoA hydratase deficiency; 9) 3-hydroxy-3-methylglutaryl-CoA lyase deficiency (HMG-CoA lyase deficiency); 10) B-ketothiolalse deficiency; 11) Homocystinuria; 12) Glutaric aciduria (types I and II); 13) Lysinuric protein intolerance; 14) Non-ketonic hyperclycinemia; 15) Propionic acidemia; 16) Gyrate atrophy; 17) Hyperornithinemia/hyperammonemia/homocitrullinuria syndrome; 18) Carbamoyl phosphate synthetase deficiency; 19) Ornithine carbamoyl transferase deficiency; 20) Citrullinemia; 21) Arginosuccinic aciduria; 22) Methylmalonic acidemia; and 23) Arginemia.

28. TELEHEALTH CONSULTATION SERVICES

Covered Services include a medical or health consultation, for purposes of patient diagnosis or treatment, that requires the use of advanced telecommunications technology, including, but not limited to: (a) Compressed digital interactive video, audio, or data transmission; (b) Clinical data transmission via computer imaging for teleradiology or telepathology; and (c) Other technology that facilitates access to other covered health care services or medical specialty expertise.

INSTRUCTIONS CONCERNING EXCLUSIONS

STANDARD EXCLUSION LANGUAGE FOLLOWS THESE INSTRUCTIONS. EXCLUSION LANGUAGE HAS BEEN BRACKETED TO ALLOW INCLUSION OR EXCLUSION TO:

1. Explain differences between Managed Care and Indemnity Plans; and
2. Reflect network differences.

No other modifications to exclusion language are allowed.

Bracketed language [ ] is Variable language.

The following Section indicates items which are excluded from benefit consideration, and are not considered Covered Services. This information is provided as an aid to identify certain common items which may be misconstrued 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.

Acupuncture/Anesthesia by Hypnosis - Services, supplies, or other care for acupuncture, anesthesia by hypnosis, and anesthesia for non-covered services .

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 in the event 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 skin titration (Rinkel Test), cytotoxicity testing (Byran's Test), urine auto injection, provocative and neutralization testing for allergies, or for an assessment of IgG antibodies in food allergies.

Behavioral Training and Modifications - Services, supplies, or other care, which are provided for conditions related to conduct disorders (except attention deficit hyperactivity disorders), pervasive developmental disorders (except autism spectrum disorders), behavioral disorders, learning disabilities and disorders, personality disorders, or intellectual disability. Services, supplies or other care for non-chemical addictions such as gambling, sexual, spending, shopping and working addictions, codependency, or caffeine addiction. Milieu therapy, marriage counseling, Inpatient admissions for environmental change, biofeedback, neuromuscular reeducation, 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 blood, blood plasma and blood derivatives. Administration and processing of blood products, blood clotting elements, Factor 8 and 9 for blood clotting enhancements in relation to hemophilia, and gamma globulin used in the treatment of hepatitis are Covered Services.

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 or while committing or attempting to commit an assault or felony. Services, supplies or other care required while incarcerated in a federal, local or state penal institution or required while in custody of federal, local, or state 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 Kentucky law.

Cosmetic Services - Services, supplies, or other care for cosmetic surgery, and/or complications arising directly from the cosmetic services. Cosmetic services means surgical procedures performed to improve a Covered Person's appearance or to correct a deformity without restoring physical bodily function, unless Medically Necessary. 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 include but are not limited to removal of tattoos, scars, wrinkles 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; keloids; pharmaceutical regimes; nutritional procedures or treatments; rhinoplasty; epikeratophakia surgery; skin abrasions which are performed as a treatment for acne.

Custodial Care – Services, supplies, or other care rendered by or in nursing facilities, rest homes, health resorts, homes for the aged or places primarily for domiciliary or Custodial Care, self-help training or other form 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 - Except as otherwise provided, services, supplies, or other care for dental services and procedures involving tooth structures, extractions, 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. Services and supplies for maxillary and/or mandibular augmentation/implant procedures to facilitate the use of full or partial dental prostheses, fixed or removable.

Disposable Supplies – Except as otherwise provided, benefits are not provided for disposable supplies to an Outpatient including but are not limited to, ace bandages, support hosiery, pressure garments, elastic stockings, and bandaids.

Drugs - Drugs, except insulin, which could be purchased without a written prescription, or are not F.D.A. 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 to leading to improvement in health outcomes, or not included within the Plan's formulary, if any. If a Covered Person specifically requests a brand name drug, the Covered Person shall be responsible for any cost difference between the brand name drug and the generic drug.

Durable Medical Equipment, Prosthetic Appliances, Orthotic Devices - Penile implants; 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. Any Durable Medical Equipment, prosthesis, or orthotic device having convenience or luxury features which are not Medically Necessary, except that benefits for the cost of 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. Benefits are excluded for the repair, maintenance and/or replacement of Durable Medical Equipment, except as otherwise provided. Adjustments made to vehicles, air purifiers, humidifiers, dehumidifiers, stair-glider, Emergency Alert equipment, handrails, heat appliances, waterbeds, whirlpool baths, exercise and massage equipment.

Education - Services, supplies, or other care for educational or training procedures used in connection with speech, hearing, or vision.

Effective Dates - Except as otherwise required by law, services, supplies, or other care rendered prior to the Effective Date of this Plan, or after the termination date of this Plan, or services, supplies, or other care rendered prior to the Covered Person's Effective Date or after the Covered Person's termination date.

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 Services.

Eye Related Services - Eyeglasses (including contact lenses) and examinations for them, 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, including but not limited to radial keratotomy or keratomileusis.

Family Member Provider - Services, supplies, or other care rendered by a Provider who is a member of the Covered Person's immediate family. Immediate family includes you, your spouse, child, brother, sister, parent or in-law of you or your spouse.

Foot Related Services - Services, supplies for routine foot care or other care used in treatment of superficial lesions of the feet such as corns, hyperkeratosis, bunions, tarsalgia, metatarsalgia (except capsular or bone surgery), callouses, nails of the feet (except mycotic infections or surgery for ingrown nails), flat feet, fallen arches, weak feet, or similar conditions, 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 Affairs 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 screening other than 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. Except as otherwise provided, hearing aids.

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 Health Care - Benefits are not provided for food, housing, home delivered meals, and homemaker services (such as housekeeping, laundry, shopping and errands). Teaching household routine to members of your family; supervision of your 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; such materials include handrails, 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 not otherwise covered by Medicare's Hospice benefit.

Infertility - Services, supplies, or other care for fertility studies, artificial insemination, or in-vitro fertilization, surrogate pregnancies, embryo transport, gamete intra-Fallopian transfer, gamete/zygote embryo transfer, donor semen or eggs, gamete transfer, HLA typing (human leukocyte antigen), hormone pulsating infusions, animal egg penetration testing, reversal of elective sterilization procedures, sperm banking or other assistive reproductive services.

Inpatient Diagnostic/Therapy - Nonemergency Diagnostic Admissions for Inpatients or admissions primarily for Therapy services [, except when precertified by the Plan].

Lipectomy - Benefits are not provided for services and supplies related to suction-assisted lipectomy or diastasis recti repair, including instances when diastasis recti is associated with an umbilical or ventral hernia.

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

Medically Necessary - Services, supplies, or other care not Medically Necessary for the diagnosis or treatment of a physical or mental illness, injury, or symptomatic complaint (see definition of Medically Necessary). The Plan may determine that a service ordered, prescribed, or recommended by a Provider does not meet the criteria set forth in the definition of Medically Necessary and therefore that service is not Medically Necessary.

Medical Records - Services, supplies, or other care for which the Plan has been unable to obtain information from a Provider or the Covered Person sufficient to determine Medical Necessity or adjudicate any claim.

Mental Health Services - Services for Mental Health Conditions when performed by other than a Physician or Provider licensed or certified by the Commonwealth of Kentucky or corresponding license or certification if provided by Physicians or other Providers outside the Commonwealth. Services for Mental Health Conditions when provided to a Covered Person for purposes of medical, educational, or occupational training. Psychological testing beyond that necessary to establish the 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.

[Network Restrictions - Services, supplies or other care provided that do not meet Plan's Health Care Delivery Systems guidelines. Please refer to your Plan's guidelines.]

Non-Covered Services - Services, supplies, or other care not specifically provided for in this [Certificate] [Policy]. Eligible Expenses exceeding any maximum benefit available under the Plan. Complications of a non-covered service.

Non-Medical Services - Services, supplies or other care for personal hygiene, environmental control, or convenience items (including, but not limited to, 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, allergenic 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.

[Non-Participating Providers - Services, supplies or other care delivered in a manner inconsistent with your Plan's Health Care Delivery System.]

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 – Except as otherwise provided for the treatment of inborn errors of metabolism or genetic conditions, food, food supplements, minerals, vitamins, or drugs which could be purchased without a written prescription, or are not F.D.A. approved for treatment of a specified category of medical conditions, or are not Medically Necessary, or are considered to be an Experimental or Investigational Service.

Obesity - Weight reduction programs or treatment for obesity (except for surgery for morbid obesity where the condition has developed to be of a life-threatening nature to the Covered Person) 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/bubble/gastric balloon procedures. Additional examples of excluded services are stomach stapling, wiring of the jaw, liposuction, dietary supplements, diet pills and appetite suppressants, and jejunal bypasses.

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.

(HEALTH MAINTENANCE ORGANIZATIONS ONLY)
[Out of Area Services - Except for services for Emergency Medical Conditions and Urgent Care, benefits are not provided for services outside the Service Area which would be provided by the Plan within the Service Area, or were furnished after the Member's condition would permit the Member to return to the Service Area for continued care.]

Outside United States - Non-emergency treatment provided outside the United States.

Physical Exams/Immunizations - Except as otherwise provided, services, supplies, or other care for routine or periodic physical examinations, or tests for screening purposes required by third parties, such as for employment, licensing, travel, school (except approved well visits), insurance, marriage, adoption, participation in athletics, or services conducted for the part of medical research or examination required by a court, or for immunizations.

(GROUP ONLY)
[Preexisting 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 from an individual licensed or similarly authorized to provide such services under state law and operating within the scope of practice authorized under state law, within the [insert a number not greater than 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 [insert a number not to exceed 12] months [or [insert a number not to exceed 18] months for a Late Enrollee] following the Enrollment Date. The Preexisting Condition exclusion does not apply to (1) pregnancy, (2) genetic information in the absence of a diagnosis, (3) domestic violence, or (4) children under the age of 19.

(INDIVIDUAL ONLY)
[Preexisting 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 from an individual licensed or similarly authorized to provide such services under state law and operating within the scope of practice authorized under state law, within the [insert a number not greater than 6] month period ending on the Covered Person's Enrollment Date. Exclusion of coverage for a Preexisting Condition may not exceed a period of [insert a number not to exceed 12] months beginning on the Effective Date. The Preexisting Condition exclusion does not apply to (1) genetic information in the absence of a diagnosis, (2) domestic violence, (3) children under the age of 19, [or] (4) Eligible Individuals [, or (5) pregnancy].

[Primary Care Physician Treatment/Referral - Services, supplies or other care provided that do not meet Plan's Health Care Delivery Systems guidelines. Please refer to your Plan's guidelines.]

Sex Transformation /Sexual Dysfunction - Services, supplies or other care related to sex transformation, sexual dysfunction or inadequacies.

Travel/Transportation - Except as otherwise provided, travel or transportation expenses, even though prescribed by a Physician.

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 workers' 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 whether or not 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.

INSTRUCTIONS CONCERNING GENERAL PROVISIONS

STANDARD LANGUAGE HAS NOT BEEN DEVELOPED FOR THIS SECTION.

[GENERAL PROVISIONS (including as applicable:)

Grandfathered plan notice
Eligibility
Enrollment
Refusal to Accept Treatment
Claims Provisions
Coordination of Benefits and Subrogation
Termination of Coverage
Extension of Benefits *
State and Federal Continuation of Coverage
Conversion
Miscellaneous (Conformity with State Statutes, Assignment, etc.)
Carrier Specific Information

* All extension of benefit provisions for group policies must include the following definitions for disability and total disability: Disability means the state of being hospitalized on the date for replacement coverage. Total disability means your continuing inability as a result of injury or sickness to perform the material and substantial duties of any occupation for which you are suited by reason of education, training or experience or, if not employed, you are confined to a Hospital or completely incapacitated when coverage under the certificate would otherwise terminate.]

INSTRUCTIONS CONCERNING
SUPPLEMENTAL BENEFIT RIDERS

STANDARD SUPPLEMENTAL BENEFIT RIDER LANGUAGE FOLLOWS THESE INSTRUCTIONS. SUPPLEMENTAL BENEFIT RIDER LANGUAGE HAS BEEN BRACKETED TO ALLOW INCLUSION OR EXCLUSION OF LANGUAGE TO:

1. Reflect the Plan with which Riders can be offered;
2. Reflect differences between Managed Care and Fee For Service Plans;
3. Reflect network differences; and
4. Reflect language that can be inserted to address exclusions.

In order to comply with Kentucky law, certain "mandated benefits" must be made available with the standard plan. The following riders are required to be offered as noted:

Mental Health Rider - must be offered with the FFS, PPO, POS and HMO standard plan

Other standard supplemental benefit riders may be offered at the option of the Plan.

MENTAL HEALTH RIDER
(Mandated Benefit Offer for All Plans)

GENERAL INFORMATION

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

B. The services provided by this rider are subject to:

- [the Deductible specified on the Schedule of Benefits;]
- the [Coinsurance] [Copayment] (if any) as specified on the Schedule of Benefits under the [Certificate] [Policy] as provided for in Hospital care and Provider office visits.

C. Payments [(except the Deductible)] made by the Covered Person for services provided by this rider will count toward satisfying the Out-of-Pocket Limit specified in the Schedule of Benefits.

DEFINITIONS Section is hereby amended as follows:

Mental Illness - Refer to the Mental Health Services Definition in the [Certificate] [Policy].

BENEFITS Section is hereby amended as follows:

MENTAL HEALTH SERVICES

Coverage for the Inpatient and Outpatient treatment of mental illness is provided to the same extent and degree as for the treatment of physical illness.

SCHEDULE OF BENEFITS is hereby amended as follows:

Specific limitations on Inpatient days and Outpatient visits for Mental Health Services are deleted.

EXPANDED HOME HEALTH CARE RIDER
(Optional Rider)

GENERAL INFORMATION

A. The [Certificate of Coverage] [Policy] 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] [Policy]. Benefits are subject to Plan Delivery System Rules, Exclusions, limitations, and all other provisions of the [Certificate] [Policy], except as specifically provided for in the rider.

B. The services provided by this rider are subject to:

- [the Deductible specified on the Schedule of Benefits;]

- [the [Coinsurance] [Copayment] (if any) as specified on the Schedule of Benefits under the [Certificate] [Policy].]

C. Payments [(except for the Deductible)] made by the Covered Person for services provided by this rider will count toward satisfying the Out-of-Pocket Limit specified in the Schedule of Benefits.

BENEFITS Section is hereby amended as follows:

Home Health Care Services as necessary to avoid or reduce hospitalization of a Covered Person. Services must be preauthorized by the Plan and may include the provision of intermittent Skilled Nursing Care; intermittent physical therapy, occupational therapy, and speech therapy; part-time or intermittent home health aide services, when under the supervision of a registered nurse; medical supplies, laboratory services and intravenous drug therapy administered during a Home Health Visit. A visit of 4 hours or less by a home health aide service is considered one Home Health Care visit.

The Plan will not pay for services not authorized by the Plan, included in the Physician's prescribed treatment plan, services of an immediate family member or Custodial Care.

MAXIMUM AMOUNT OF COVERED SERVICES

The number of visits specified on the Schedule of Benefits is deleted. This Rider will not duplicate any benefits paid by the Plan.

THREE TIER PRESCRIPTION DRUG RIDER
(Optional Rider)
The Three Tier Prescription Drug Rider can be offered with the PPO, POS and HMO Plan Designs

GENERAL INFORMATION

A. The [Certificate of Coverage] [Policy] 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] [Policy]. Benefits are subject to Plan Delivery System Rules, Exclusions, limitations, and all other provisions of the [Certificate] [Policy], except as specifically provided for in the rider.

B. The services provided by this rider are subject to:

In-Network	Out-of-Network
Generic Drugs: $10 Copayment per prescription	No Coverage
Brand Name Drugs: $15 Copayment per prescription	No Coverage
Non-Formulary Drugs: $30 Copayment per prescription	No Coverage

C. Payments made by the Covered Person for services provided by this rider will not count toward satisfying the Out-of-Pocket Limit specified in the Schedule of Benefits.

D. This rider does not duplicate any prescription drug benefit otherwise provided in the [Certificate] [Policy].

BENEFITS Section is hereby amended as follows:

PRESCRIPTION DRUGS

Prescription drug coverage is limited to injectable insulin, syringes, blood glucose and urine reagent test strips, 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 during the period a Covered Person is eligible to receive benefits under the Plan by a licensed pharmacy Provider for the Outpatient use of the Covered Person.

Benefits for covered prescription drugs are limited to quantities which can reasonably be expected to be consumed or used within one month, or as otherwise authorized by the Plan.

Refer to your Plan's Health Delivery System Rules regarding generic drugs [and any use of formularies and mail order programs]. If a Covered Person specifically requests a brand name drug, the Covered Person shall be responsible for any difference between the brand name drugs and the Generic Drug.

Refer to your Plan’s Delivery System Rules regarding the refill exceptions and override policy.

EXCLUSIONS Section is hereby amended by adding the following:

Drugs - 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 to leading to improvement in health outcomes. If a Covered Person specifically requests a brand name drug, the Covered Person shall be responsible for any cost difference between the brand name drug and the generic drug.

[$7] [$15] PRESCRIPTION DRUG RIDER
(Optional Rider)
The $7 and $15 Prescription Drug Riders can be offered with the Fee for Service and PPO Plans.
The $7 Prescription Drug Rider can be offered with the POS and HMO Plans.

GENERAL INFORMATION

A. The [Certificate of Coverage] [Policy] 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] [Policy]. Benefits are subject to Plan Delivery System Rules, Exclusions, limitations, and all other provisions of the [Certificate] [Policy], except as specifically provided for in the rider.

B. The services provided by this rider are subject to:

- [$7] [$15] Copayment per prescription.

C. Payments made by the Covered Person for services provided by this rider will not count toward satisfying the Out-of-Pocket Limit specified in the Schedule of Benefits.

D. This rider does not duplicate any prescription drug benefit otherwise provided in the [Certificate] [Policy].

BENEFITS Section is hereby amended as follows:

PRESCRIPTION DRUGS

Prescription drug coverage is limited to injectable insulin, syringes, blood glucose and urine reagent test strips, 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 FDA, and which are adopted by the Plan. The drugs must be dispensed during the period a Covered Person is eligible to receive benefits under the Plan by a licensed pharmacy Provider for the Outpatient use of the Covered Person.

Benefits for covered prescription drugs are limited to quantities which can reasonably be expected to be consumed or used within one month, or as otherwise authorized by the Plan.

Refer to your Plan's Health Delivery System Rules regarding generic drugs [and any use of formularies and mail order programs]. If a Covered Person specifically requests a brand name drug, the Covered Person shall be responsible for any difference between the brand name drugs and the Generic Drug.

Refer to your Plan's Delivery System Rules regarding the refill exceptions and override policy.

EXCLUSIONS Section is hereby amended by adding the following:

Drugs - 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 to leading to improvement in health outcomes, or not included within the Plan's formulary, if any. If a Covered Person specifically requests a brand name drug, the Covered Person shall be responsible for any cost difference between the brand name drug and the generic drug.

FERTILITY SERVICES RIDER
(Optional Rider)

GENERAL INFORMATION

A. The [Certificate of Coverage] [Policy] 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] [Policy]. Benefits are subject to Plan Delivery System Rules, Exclusions, limitations and all other provisions of the [Certificate] [Policy], except as specifically provided for in the rider.

B. The services provided by this rider are subject to:

- [the Deductible specified on the Schedule of Benefits;]
- A 50% Coinsurance.

C. Payments [(except for the Deductible)] made by the Covered Person for services provided by this rider will not count toward satisfying the Out-of-Pocket Limit specified in the Schedule of Benefits.

BENEFITS Section is hereby amended as follows:

FERTILITY SERVICES

Diagnosis and treatment of infertility including artificial insemination, drug therapy, and surgery related to infertility. Assisted reproductive technology (ART) procedures that enable a woman with otherwise untreatable infertility to become pregnant through other artificial conception procedures such as in vitro fertilization and embryo transfer are not covered.

EXCLUSIONS Section is hereby amended as follows:

Infertility - Services, supplies or other care for in vitro fertilization, surrogate pregnancies, embryo transport, gamete intra-Fallopian transfer, gamete/zygote embryo transfer, reversal of elective sterilization procedures, sperm banking or other assistive reproductive services.

ELECTIVE ABORTION RIDER
(Optional Rider)

GENERAL INFORMATION

A. The [Certificate of Coverage] [Policy] 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] [Policy]. Benefits are subject to Plan Delivery System Rules, Exclusions, limitations, and all other provisions of the [Certificate] [Policy], except as specifically provided for in the rider.

B. The services provided by this rider are subject to:

- [the applicable Deductible specified on the Schedule of Benefits for Inpatient and/or Outpatient Hospital and surgical services;]

- [the applicable [Coinsurance] [Copayment] (if any) as specified on the Schedule of Benefits for Inpatient and/or Outpatient Hospital and surgical services under the [Certificate] [Policy].

C. Payments [(except for the Deductible)] made by the Covered Person for services provided by this rider will count toward satisfying the Out-of-Pocket Limit specified in the Schedule of Benefits.

DEFINITIONS Section is hereby amended as follows:

Elective Abortion - an abortion for any reason other than to preserve the life of the female upon whom the abortion is performed.

BENEFITS Section is hereby amended as follows:

ABORTION COVERAGE

Coverage is provided for Inpatient and/or Outpatient Hospital and surgical services for an elective abortion.

EXCLUSIONS Section is hereby amended as follows:

The exclusion for services, supplies, and other care provided for elective abortions, as defined by Kentucky law, is deleted.

DENTAL CARE RIDER
(Optional Rider)

GENERAL INFORMATION

A. The [Certificate of Coverage] [Policy] 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] [Policy]. Benefits are subject to Plan Delivery System Rules, Exclusions, limitations, and all other provisions of the [Certificate] [Policy], except as specifically provided for in the rider.

B. The benefits provided by this rider are subject to a $500 maximum benefit per Plan Year for each Covered Person.

BENEFITS Section is hereby amended as follows:

PREVENTIVE DENTAL CARE

Coverage is provided in full for Eligible Expenses incurred for preventive and diagnostic dental services for the following procedures:

i. Routine periodic oral examinations - two per Covered Person in any 12 consecutive months;

ii. X-rays (complete services, including panoramic film, with or without bitewings) - one per Covered Person in any 36 consecutive months;

iii. X-rays (bitewing) - two sets per Covered Person in any 12 consecutive months;

iv. Routine prophylaxis (cleaning) - two per Covered Person in any 12 consecutive months;

v. Topical application of an acid fluoride phosphate to Covered Persons under 19 years of age - one per Covered Person in any 12 consecutive months;

vi. Topical application of sealant on the occlusal surface of a permanent posterior tooth to Covered Persons under 14 years of age - one treatment per tooth in any 36 consecutive months.

EXCLUSIONS Section is hereby amended as follows:

The Dental Services exclusion is deleted to the extent it conflicts with this rider. Instructions for plaque control, oral hygiene, or diet are excluded. Dental treatment that fails to meet common dental standards is excluded. Charges in excess of Eligible Expenses or the annual benefit maximum are excluded. Charges for (a) non-routine examinations (including but not limited to exams for periodontics, oral surgery, orthodontics, and endodontics); (b) non-routine prophylaxis (including but not limited to periodontal prophylaxis and periodontal scaling); and (c) restorative procedures (fillings and crowns), endodontics, periodontics, prosthodontics (dentures), oral surgery, and orthodontics are excluded.

EXPANDED VISION CARE RIDER
(Optional Rider)

GENERAL INFORMATION

A. The [Certificate of Coverage] [Policy] 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] [Policy]. Benefits are subject to Plan Delivery System Rules, Exclusions, limitations, and all other provisions of the [Certificate] [Policy], except as specifically provided for in the rider.

B. The services provided by this rider are subject to:

- [the Deductible specified on the Schedule of Benefits;]
- [The Copayment/Coinsurance as specified in the Schedule of Benefits under Outpatient Services;]

C. Payments [(except for the Deductible)] made by the Covered Person for services provided by this rider will count toward satisfying the Out-of-Pocket Limit specified in the Schedule of Benefits. Any amounts exceeding the Eligible Expense for frames and lenses will not apply toward the satisfaction of the Deductible.

BENEFITS Section is hereby amended as follows:

VISION CARE SERVICE

Routine vision examinations (refractions) for the purpose of obtaining prescriptions, lenses and frames. Benefits are limited to one examination each twelve (12) months up to age 18, and one exam each twenty-four (24) months after age 18.

- a $100 maximum benefit each Plan Year for frames and lenses, including contact lens, for a Covered Person up to age 18, and every other year thereafter.

EXCLUSIONS Section is hereby amended as follows:

The exclusion for Eye Related Services is deleted, except for the treatment for the correction of refractive error, including but not limited to radial keratotomy or keratomileusis.

BASIC VISION CARE RIDER
(Optional Rider)

GENERAL INFORMATION

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

B. The services provided by this rider are subject to:

[the Deductible specified on the Schedule of Benefits;]

[The Copayment/Coinsurance as specified in the Schedule of Benefits under Outpatient Services]

C. Payments [(except for the Deductible)] made by the Covered Person for services provided by this rider will count toward satisfying the Out-of-Pocket Limit specified in the Schedule of Benefits.

BENEFITS Section is hereby amended as follows:

VISION CARE SERVICES

Routine vision examinations (refractions) for the purpose of obtaining prescriptions, lenses and frames. Benefits are limited to one examination each twelve (12) months up to age 18, and one exam each twenty-four (24) months after age 18. Benefits are not provided for lenses or frames.

EXCLUSIONS Section is hereby amended as follows:

The exclusion for Eye Related Services is partially deleted, but only to the extent that the exclusion involves eye examinations.

ACCIDENTAL INJURY RIDER

(Optional Rider for the Fee for Service and PPO Plans)

GENERAL INFORMATION

A. The [Certificate of Coverage] [Policy] 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] [Policy]. Benefits are subject to the Plan Delivery System Rules, Exclusions, limitations, and all other provisions of the [Certificate] [Policy], except as specifically provided for in this rider.

B. Benefits provided by this rider are limited to 100% of the Eligible Expense for Covered Services for the treatment of an Accidental Injury as defined in the Definitions section of the [Certificate] [Policy]. Coverage is limited to $500 per Accidental Injury.

C. (Indemnity Plans Only) [The initial visit at a Hospital emergency room (if applicable) is a Covered Service. Follow-up care from a Provider other than a Hospital emergency room is also a Covered Service under this rider.]

(PPO Plans Only) [The initial visit at a Hospital emergency room (if applicable) is a Covered Service. Medically Necessary follow-up care at a Hospital emergency room is a Covered Service if an Accidental Injury occurs outside the Service Area. Follow-up care from a Provider other than a Hospital emergency room is also a Covered Service under this rider.]

D. Treatment must begin within the first thirty (30) days from the day following the date of the Accidental Injury. Coverage will extend up to ninety (90) days following the date of the Accidental Injury.

E. Covered Services provided by this rider are not subject to the Deductible and [Copayment and] Coinsurance provisions of the [Certificate] [Policy]. Payments made by the Covered Person for services covered under this rider will not count toward satisfying the Deductible or Out-of-Pocket Limit specified in the Schedule of Benefits.

F. Charges in excess of the benefits provided herein, or incurred more than 90 days following the date of the Accidental Injury, are subject to the Deductible and [Copayment and] Coinsurance provisions of the [Certificate] [Policy].