# Benefits for Health Care Coverage

# Kentucky Benchmark Plan


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# Section 1: Covered Health Services

## Benefits for Covered Health Services

Benefits are available only if all of the following are true:

- The health care service, supply or Pharmaceutical Product is only a Covered Health Service if it is Medically Necessary, except as explicitly stated medical necessity is not a required determination. (See definitions of Medically Necessary and Covered Health Service(s) in *Section 3: Defined Terms.)* The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance use disorder, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Service under the Policy.
- Covered Health Services are received while the Policy is in effect.
- Covered Health Services are received prior to the date that any of the individual termination conditions occur.
- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements specified in the Policy.

This section describes Covered Health Services for which Benefits are available, subject to:

- The amount the insured must pay for these Covered Health Services (including any Annual Deductible, Copayment and/or Coinsurance).
- Any limit that applies to these Covered Health Services (including visit, day and dollar limits on services).
- Any limit that applies to the amount the insured is required to pay in a year (Out-of-Pocket Maximum).

Benefits for Prescription Drug Products are described in *Section 4: Outpatient Prescription Drug.* Benefits for pediatric Dental Services are described in *Section 5: Pediatric Dental Services.* Benefits for pediatric Vision Care Services are described in *Section 6: Pediatric Vision Care Services.*

*Please note that in listing services or examples, when the carrier says, "this includes," it is not the carrier's intent to limit the description to that specific list. When the carrier does intend to limit a list of services or examples, the carrier states specifically that the list "is limited to."*

### 1. Ambulance Services

Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance) to the nearest Hospital where Emergency Medical Services can be performed.

Non-Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as the carrier determines appropriate) between facilities when the transport is any of the following:

- From a out-of-network Hospital to a Network Hospital.
- To a Hospital that provides a higher level of care that was not available at the original Hospital.
- To a more cost-effective acute care facility.
- From an acute facility to a sub-acute setting.
- From a Hospital to a Skilled Nursing Facility.
- From a Hospital or Skilled Nursing Facility to the Covered Person's home.

## 2. Clinical Trials

Benefits under this section include routine patient care costs incurred during participation in both qualifying clinical trials other than cancer clinical trials and cancer clinical trials. Covered Health Services for qualifying clinical trials other than cancer clinical trials are described immediately below under Covered Health Services for cancer clinical trials are described at the end of this section under *Cancer Clinical Trials.*

**Clinical Trials Other Than Cancer Clinical Trials**

Routine patient care costs incurred during participation in a qualifying clinical trial for the treatment of:

- A life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.
- Cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as the carrier determine, a clinical trial meets the qualifying clinical trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which, as the carrier determines, a clinical trial meets the qualifying clinical trial criteria stated below.
- Other diseases or disorders which are not life threatening for which, as the carrier determines, a clinical trial meets the qualifying clinical trial criteria stated below.

Benefits include the reasonable and necessary items and services used to diagnose and treat complications arising from participation in a qualifying clinical trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the clinical trial as defined by the researcher.

Routine patient care costs for qualifying clinical trials include:

- Covered Health Services for which Benefits are typically provided absent a clinical trial.
- Covered Health Services required solely for the provision of the Investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service or item. The only exceptions to this are:
    - Certain *Category B* devices.
    - Certain promising interventions for patients with terminal illnesses.
    - Other items and services that meet specified criteria in accordance with the carrier's medical and drug policies.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

With respect to other life-threatening diseases or conditions, a qualifying clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of another life-threatening disease or condition and which meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease or musculoskeletal disorders of the spine, hip and knees which are not life-threatening, a qualifying clinical trial is a Phase I, Phase II, or Phase III clinical trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
    - *National Institutes of Health (NIH).*
    - *Centers for Disease Control and Prevention (CDC).*
    - *Agency for Healthcare Research and Quality (AHRQ).*
    - *Centers for Medicare and Medicaid Services (CMS).*
    - A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA).*
    - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
    - The *Department of Veterans Affairs,* the *Department of Defense* or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
        - Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health.*
        - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation is conducted under an investigational new drug application reviewed by the *U.S. Food and Drug Administration*.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. The carrier may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Policy.

**Cancer Clinical Trials**

Benefits under this section include routine patient health care costs incurred during participation in a cancer clinical trial as required under Kentucky insurance law.

Routine patient health care costs for cancer clinical trials include Covered Health Services for which Benefits are typically provided absent a cancer clinical trial.

For the purpose of this Benefit, the following definitions apply:

"Cancer clinical trial" means a clinical trial that meets the following criteria:

- The trial must meet the criteria of and be approved by one of the following entities:
    - *National Institutes of Health (NIH)* or any institutional review board recognized by the *NIH*.
    - *United States Food and Drug Administration (FDA)*.
    - *United States Department of Defense (DOD)*.
    - *United States Veterans' Administration (VA)*.
- The trial must do one of the following:
    - Test how to administer a health care service, item or drug for the treatment of cancer.
    - Test responses to a health care service, item or drug for the treatment of cancer.
    - Compare the effectiveness of health care services, items or drugs for the treatment of cancer with other health care services, items or drugs for the treatment of cancer.
    - Study new uses of health care services, items or drugs for the treatment of cancer.

"Routine patient health care costs" means all health care services, items and drugs for the treatment of cancer except the following:

- Health care services, items or investigational drugs that are the subject of the cancer clinical trial. Treatment modalities outside the usual and customary standard of care required to administer or support the health care service, item or investigational drug that is the subject of the cancer clinical trial.
- Health care services, items or drugs provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient.
- Investigational drugs or devices that have not been approved for market by the *FDA*.
- Transportation, lodging, food or other expenses for the patient, a family member or companion of the patient that are associated with travel to or from the facility providing the cancer clinical trial.
- Services, items or drugs provided by the cancer clinical trial sponsors free of charge for any new patient.
- Services, items or drugs that are eligible for reimbursement by a person other than the carrier, including the sponsor of the cancer clinical trial.

## 3. Congenital Heart Disease Surgeries

Congenital heart disease (CHD) surgeries which are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels and hypoplastic left or right heart syndrome.

Benefits under this section include the facility charge and the charge for supplies and equipment. Benefits for Physician services are described under *Physician Fees for Surgical and Medical Services.*

Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

## 4. Dental Services - Accident Only

Dental services when all of the following are true:

- Treatment is necessary because of accidental damage.
- Dental services are received from a Doctor of Dental Surgery, Doctor of Medical Dentistry or a Physician who acts within the scope of his or her license.
- The dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the injury and if extenuating circumstances exist due to the severity of the injury.)

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered having occurred as an accident. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

Dental services to repair damage caused by accidental injury must conform to the following time-frames:

- Treatment is started within three months of the accident, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care).
- Treatment must be completed within 12 months of the accident.

Benefits for treatment of accidental injury are limited to the following:

- Emergency examination.
- Necessary diagnostic X-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (filings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to the injury by implant, dentures, or bridges.

## 5. Diabetes Services

Benefits under this section for diabetes services are available to Covered Persons with insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin-using diabetes.

**Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care**

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Diabetes outpatient self-management training, education and medical nutrition therapy services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals.

Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes.

**Diabetic Self-Management Items and Medications**

Insulin pumps, supplies and medications for the management and treatment of diabetes, based upon the medical needs of the Covered Person. An insulin pump is subject to all the conditions of coverage stated under *Durable Medical Equipment.* Benefits for medications, blood glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described in *Section 4: Outpatient Prescription Drug Products.*

## 6. Durable Medical Equipment

Durable Medical Equipment that meets each of the following criteria:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered Durable Medical Equipment.
- Not of use to a person in the absence of a disease or disability.

Benefits under this section include Durable Medical Equipment provided to the insured by a Physician.

If more than one piece of Durable Medical Equipment can meet the insured's functional needs, Benefits are available only for the equipment that meets the minimum specifications for the insured's needs.

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Negative pressure wound therapy pumps (wound vacuums).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related necessary supplies as described under *Diabetes Services*.
- External cochlear devices and systems and include cochlear implants for Covered Persons who are diagnosed with profound hearing impairment as required under Kentucky insurance law.

Benefits under this section also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the

purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period.

Benefits under this section do not include any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body.

The carrier will decide if the equipment should be purchased or rented.

Benefits are available for repairs and replacement, except that:

- Benefits for repair and replacement do not apply to damage due to misuse, malicious breakage or gross neglect.
- Benefits are not available to replace lost or stolen items.

## 7. Emergency Medical Services - Outpatient

Services that are required to screen, stabilize or initiate treatment in an Emergency. Emergency Medical Services must be received on an outpatient basis at a Hospital or Alternate Facility. Emergency personnel will contact the Covered Person's Primary Physician or the carrier as quickly as possible to discuss follow-up, post-stabilization and continuity of care.

Benefits under this section include the facility charge, supplies and all professional services required to screen and stabilize the insured's condition and/or initiate treatment. This includes placement in an observation bed for the purpose of monitoring the insured's condition (rather than being admitted to a Hospital for an Inpatient Stay).

Benefits under this section are not available for services to treat a condition that does not meet the definition of an Emergency.

Note: If the insured is confined in a out-of-network Hospital after the insured receives outpatient Emergency Medical Services, the insured must notify the carrier within one business day or on the same day of admission if reasonably possible. The carrier may elect to transfer the insured to a Network Hospital as soon as is medically appropriate to do so. If the insured chooses to stay in the out-of-network Hospital after the date the carrier decides is medically appropriate, Network Benefits will not be provided. Out-of-network Benefits may be available if the continued stay is determined to be a Covered Health Service.

## 8. Hearing Aids

Hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound, which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier, and receiver.

Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician. Benefits are provided for the hearing aid and for charges for associated fitting and testing.

Benefits under this section do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Services categories and only for Covered Persons who have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Benefits under this section include hearing aids and all related services when prescribed by a licensed audiologist and dispensed by a licensed hearing instrument specialist as required under Kentucky insurance law. The carrier will not pay a claim for the cost of a hearing aid under this Benefit if such a claim was paid under any insurance policy in the past 36 months.

For the purpose of this Benefit, the following definitions apply:

"Hearing aid" means any wearable, non-disposable instrument or device designed to aid or compensate for impaired human hearing and any parts, attachments or accessories, including earmolds, but excluding batteries and cords.

"Related services" means those services necessary to assess, select and appropriately adjust or fit the hearing aid to ensure optimal performance.

## 9. Home Health Care

Services received from a Home Health Agency that are both of the following:

- Ordered by a Physician.
- Provided in the insured's home by a registered nurse, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.

Benefits are available only when the Home Health Agency services are provided on a part-time, Intermittent Care schedule and when skilled care is required.

Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

The carrier will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are also included for Private Duty Nursing services provided in the home when provided through a Home Health Agency and authorized in advance by the carrier. The insured's Physician must certify to the carrier that Private Duty Nursing services are Medically Necessary for the insured's condition and not merely custodial in nature. Private Duty Nursing services may be provided if they are determined by the carrier to be more cost effective than can be provided in a facility setting.

## 10. Hospice Care

Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social, spiritual and respite care for the terminally ill person and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available when hospice care is received from a licensed hospice agency. Benefits for hospice care, in-network and out-of-network, will not be less than the hospice care benefits provided by Medicare. Benefits are provided for:

- Physician and nursing services.
- Drugs for pain relief and symptom management.
- Physical therapy, occupational therapy, and speech therapy.
- Medical, social services, and counseling for the terminally ill person and family members; and
- Short-term inpatient care, including respite care, that is a short stay for the person with terminal illness, intended to give temporary relief to the person who regularly assists with home care.

In addition, for Out-of-network Benefits, the insured must contact the carrier within 24 hours of admission for an Inpatient Stay in a hospice facility.

## 11. Hospital - Inpatient Stay

Services and supplies provided during an Inpatient Stay in a Hospital. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

In addition, for Out-of-network Benefits the insured must contact the carrier within 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

## 12. Lab, X-Ray and Diagnostics - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office include:

- Allergy testing.
- Lab and radiology/X-ray.
- Mammography.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists, and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

When these services are performed in a Physician's office, Benefits are described under Physician's Office Services - Sickness and Injury.

Lab, X-ray and diagnostic services for preventive care are described under Preventive Care Services.

CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient.

Biomarker Testing when ordered by a Qualified Health Care Provider operating within the provider's scope of practice for the purpose of diagnosis, treatment, appropriate management, or ongoing monitoring of an insured's disease or condition when the test is supported by medical and scientific evidence, including but not limited to:

(a) Labeled indications for an FDA-approved or FDA-cleared test;

(b) Indicated tests for an FDA-approved drug;

(c) Warnings and precautions on FDA-approved drug labels;

(d) Centers for Medicare and Medicaid Services national coverage determinations;

(e) Medicare Administrative Contractor local coverage determinations;

(f) Nationally recognized clinical practice guidelines; or

(g) Consensus statements.

## 13. Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.

- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under Physician Fees for Surgical and Medical Services.)

## 14. Mental Health Services

Mental Health Services include those received on an inpatient basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.

Benefits include the following services provided on either an inpatient or outpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment.
- Services at a Residential Treatment Facility.

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

The insured is encouraged to contact the Mental Health/Substance Use Disorder Designee for referrals to providers and coordination of care.

**Special Mental Health Programs and Services**

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Designee may become available to the Covered Person as a part of the Mental Health Services Benefit. The Mental Health Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of the Covered Person’s Mental Illness, which may not otherwise be covered under the Policy. The Covered Person must be referred to such programs through the Mental Health/Substance Use Disorder Designee, who is responsible for coordinating care or through other pathways as described in the program introductions. Any decision to participate in such a program or service is the choice of the Covered Person and is not mandatory.

## 15. Neurobiological Disorders - Autism Spectrum Disorder Services

Psychiatric services for Autism Spectrum Disorders that are both of the following:

- Provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider.
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self or others or property, or impairment in daily functioning.

This section describes only the psychiatric component of treatment for Autism Spectrum Disorders for which Benefits are not subject to any age limit. Medical treatment of Autism Spectrum Disorders for all Covered Persons is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Services categories.

Benefits include the following services provided on either an inpatient or outpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Referral services.
- Medication management. Benefits for prescription medications are provided as described in *Section 4: Outpatient Prescription Drug Products*.
- Individual, family, therapeutic group and provider-based case management services. Crisis intervention.
- Direct or consultative psychological care services provided 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.
- Direct or consultative psychiatric care services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment.
- Services at a Residential Treatment Facility.

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

For the purpose of this Benefit, "diagnostic evaluations and assessments" means medically necessary assessments, evaluations, or tests to diagnose whether a Covered Person has any of the Autism Spectrum Disorders, including test tools which are appropriate to the presenting characteristics and age of the Covered Person and can be empirically validated for Autism Spectrum Disorders to provide evidence that meets the criteria for Autism Spectrum Disorders in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

Enhanced Autism Spectrum Disorder services that are focused on educational/behavioral interventions that are habilitative in nature and that are backed by credible research demonstrating that the services or supplies have a measurable and beneficial effect on health outcomes. Benefits are provided for intensive behavioral therapies (educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction, and learning, such as *Applied Behavioral Analysis (ABA)).*

The Mental Health/Substance Use Disorder Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

The insured is encouraged to contact the Mental Health/Substance Use Disorder Designee for referrals to providers and coordination of care.

A Liaison for autism spectrum disorder shall be available to facilitate communication between the member and the insurer. Call member services for more information.

## 16. Orthotic Devices

Orthotic devices that meet the following criteria:

- Custom-made, rigid, or semi-rigid supportive device.
- Used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body.
- Limit or stop motion of a weak or diseased body part.

If more than one orthotic device can meet the insured’s functional needs, Benefits are available only for the orthotic device that meets the minimum specifications for the insured’s needs.

Examples of orthotic devices include:

- Cervical collars.
- Ankle foot orthosis.
- Corsets (back and special surgical).

- Trusses and supports.
- Slings.
- Wristlets.
- Built-up shoes and therapeutic shoes for Covered Persons with diabetes.
- Custom-made shoe inserts.

Benefits are available for repairs and replacement, except that:

- Benefits for repair and replacement do not apply to damage due to misuse, malicious breakage, or gross neglect.
- Benefits are not available to replace lost or stolen items.

## 17. Ostomy Supplies

Benefits for ostomy supplies are limited to the following:

- Pouches, face plates and belts.
- Irrigation sleeves, bags, and ostomy irrigation catheters.
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesives, adhesive remover, or other items not listed above.

## 18. Pharmaceutical Products - Outpatient

Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by the carrier), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy.

## 19. Physician Fees for Surgical and Medical Services

Physician fees for surgical procedures and other medical care received on an outpatient or inpatient basis in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, ambulatory surgical center, or for Physician house calls.

Coverage will be provided for a surgical first assistant, certified surgical assistant, physician assistant or registered nurse first assistant who performs services under the direction of the operating Physician as a first or second assistant.

## 20. Physician's Office Services - Sickness and Injury

Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury, including services provided by a Specialist Physician. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic, or located in a Hospital.

Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease, which requires the intervention of a trained health professional.

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing and Biomarker Testing, which is ordered by the Physician and authorized in advance by the carrier.

Benefits under this section include allergy injections. Benefits under this section also include consultation with a Network Physician for a second opinion.

Covered Health Services for preventive care provided in a Physician's office are described under *Preventive Care Services.*

When a test is performed or a sample is drawn in the Physician's office and then sent outside the Physician's office for analysis or testing, Benefits for lab, radiology/X-rays and other diagnostic services that are performed outside the Physician's office are described in *Lab, X-ray and Diagnostics - Outpatient.*

## 21. Pregnancy - Maternity Services

Benefits for Pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

There are also special prenatal programs to help during Pregnancy. They are completely voluntary and there is no extra cost for participating in the program. To sign up, the insured should notify the carrier during the first trimester, but no later than one month prior to the anticipated childbirth. It is important that the insured notify the carrier regarding the insured's Pregnancy. This notification will open the opportunity to become enrolled in prenatal programs designed to achieve the best outcomes for the insured and the insured's baby.

The carrier will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a normal vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

The mother and child may be discharged earlier than these minimum time frames:

- If the carrier authorize an initial post-partum home visit which includes the collection of an adequate sample for hereditary and metabolic newborn screening; and
- If the attending Physician, with the consent of the mother, authorizes a shorter Inpatient Stay based on the attending Physician's determination that the mother and newborn child meet the criteria for medical stability in the current edition of *Guidelines for Perinatal Care* prepared by the *American Academy of Pediatrics* and the *American College of Obstetricians and Gynecologists*.

**It is important that the insured notify the carrier regarding the Pregnancy. The insured's notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for the insured and the insured's baby.**

## 22. Preventive Care Services

Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*, including coverage for mammography screening as required under federal and state law, which currently provides for mammography every 1-2 years for women aged 40 and older. Benefits for mammography that do not have in effect a rating of "A" or "B" are described under Lab, X-Ray and Diagnostic-Outpatient.
- Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices* of the *Centers for Disease Control and Prevention*.

- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

Benefits under this section also include the following:

- All preventive cancer screenings consistent with nationally recognized clinical practice guidelines. The proposed coverage includes but is not limited to lung, breast, cervical, prostate, colorectal, ovarian, thyroid, skin, and pancreatic cancer screenings and includes any type of cancer being screened. Nationally recognized clinical practice guidelines include but are not limited to the *United States Preventive Services Task Force (USPSTF)*, the *American Cancer Society*, and the *National Comprehensive Cancer Network*. This includes:
  - Colorectal cancer examinations, ~~and~~ laboratory tests, and coverage for all United States Food and Drug Administration approved bowel preparation prescribed in connection with a colorectal cancer examination or laboratory test as required by Kentucky insurance law.
    - Colorectal cancer examinations and laboratory tests including those specified in and according to the frequency identified in the most recently published guidelines of the American Cancer Society as follows:
      - For non-symptomatic Covered Persons age ~~50~~ 45 or older.
      - For non-symptomatic Covered Persons under age ~~50~~ 45 and at a high risk for colorectal cancer, according to the most recent version of the United States Multi-Society Task Force on Colorectal Cancer guidelines.

Benefits include the cost of renting one breast pump per Pregnancy in conjunction with childbirth as defined under the *Health Resources and Services Administration (HRSA)* requirement and all breastfeeding services and supplies required under 42 U.S.C. sec. 300gg-13(a) and any related federal regulations, as amended.

If more than one breast pump can meet the insured's needs, Benefits are available only for the most cost effective pump. The carrier will determine the following:

- Which pump is the most cost effective.
- Whether the pump should be purchased or rented.
- Duration of a rental
- Timing of an acquisition.

Routine hearing examinations. Benefits for hearing examinations required for the diagnosis and treatment of a Sickness or Injury are provided under *Physician's Office Services - Sickness and Injury.*

## 23. Prosthetic Devices

External prosthetic devices that replace a limb or a body part, limited to:

- Artificial arms, legs, feet and hands.
- Artificial face, eyes, ears and nose.
- Breast prostheses as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras and lymphedema stockings for the arm.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body.

If more than one prosthetic device can meet the insured's functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for the insured needs. If the insured purchases a prosthetic device that exceeds these minimum specifications, the carrier will pay only the amount that the carrier would have paid for the prosthetic that meets the minimum specifications, and the insured will be responsible for paying any difference in cost.

The prosthetic device must be ordered or provided by, or under the direction of a Physician.

Benefits are available for repairs and replacement, except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.

## 24. Reconstructive Procedures

Reconstructive procedures when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the *Women's Health and Cancer Rights Act of 1998,* including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service.

Please note that Benefits are also included for reconstructive procedures to address all stages of surgical reconstruction related to an orchiectomy or orchidectomy, including testicular or other urological prostheses

## 25. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

Short-term outpatient rehabilitation services (including habilitative services), limited to:

- Physical therapy.
- Occupational therapy.
- Manipulative Treatment.
- Speech therapy.
- Pulmonary rehabilitation therapy.
- Cardiac rehabilitation therapy.
- Post-cochlear implant aural therapy.
- Cognitive rehabilitation therapy.

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed Manipulative Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive Manipulative Treatment.

Speech therapy benefits will apply for the treatment of disorders of speech, language, voice, communication and auditory processing, regardless of cause, without benefit or visit limits applied.

## Habilitative Services

Benefits are provided for habilitative services provided on an outpatient basis for Covered Persons with a congenital, genetic, or early acquired disorder when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, Physician, licensed nutritionist, licensed social worker or licensed psychologist.

- The initial or continued treatment must be proven and not Experimental or Investigational.

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not habilitative services.

A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service. When the Covered Person reaches his/her maximum level of improvement or does not demonstrate continued progress under a treatment plan, a service that was previously habilitative is no longer habilitative.

The carrier may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow the carrier to substantiate that initial or continued medical treatment is needed and that the Covered Person's condition is clinically improving as a result of the habilitative service.

When the treating provider anticipates that continued treatment is or will be required to permit the Covered Person to achieve demonstrable progress, the carrier may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

For purposes of this benefit, the following definitions apply:

- "Habilitative services" means occupational therapy, physical therapy and speech therapy prescribed by the Covered Person's treating Physician pursuant to a treatment plan to develop a function not currently present as a result of a congenital, genetic, or early acquired disorder.
- A "congenital or genetic disorder" includes, but is not limited to, hereditary disorders.
- An "early acquired disorder" refers to a disorder resulting from Sickness, Injury, trauma or some other event or condition suffered by a Covered Person prior to that Covered Person developing functional life skills such as, but not limited to, walking, talking, or self-help skills.

Speech therapy benefits will apply for the treatment of disorders of speech, language, voice, communication and auditory processing, regardless of cause, without benefit or visit limits applied.

Other than as described under *Habilitative Services* above, Benefits for cognitive rehabilitation therapy will apply only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.

## 26. Scopic Procedures - Outpatient Diagnostic and Therapeutic

Diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy and endoscopy.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for all other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

When these services are performed for preventive screening purposes, Benefits are described under *Preventive Care Services.*

## 27. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Services and supplies provided during an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay. Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Please note that Benefits are available only if both of the following are true:

- If the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost effective alternative to an Inpatient Stay in a Hospital.
- The insured will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.

The carrier will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

## 28. Substance Use Disorder Services

Substance Use Disorder Services include those received on an inpatient basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.

Benefits include the following services provided on either an inpatient or outpatient basis:

- Diagnostic evaluations and assessment.
- Emergency Detoxification Treatment for the treatment of alcoholism.
- Treatment planning.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment.
- Services at a Residential Treatment Facility.

Benefits include the following services provided on an outpatient basis: Intensive Outpatient Treatment.

Benefits under this section include treatment of alcoholism as required under Kentucky insurance law.

The Mental Health/Substance Use Disorder Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

The insured is encouraged to contact the Mental Health/Substance Use Disorder Designee for referrals to providers and coordination of care.

**Special Substance Use Disorder Programs and Services**

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Designee may become available to the insured as a part of the insured’s Substance Use Disorder Services Benefit. The

Substance Use Disorder Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of the insured's substance use disorder which may not otherwise be covered under the Policy. The insured must be referred to such programs through the Mental Health/Substance Use Disorder Designee, who is responsible for coordinating the insured's care or through other pathways as described in the program introductions. Any decision to participate in such a program or service is the choice of the Covered Person and is not mandatory.

## 29. Surgery - Outpatient

Surgery and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, and hysteroscopy.

Examples of surgical procedures performed in a Physician's office are mole removal and ear wax removal.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists, and pathologists. (Benefits for other Physician services are described under Physician Fees for Surgical and Medical Services.)
- Coverage for an orchiectomy or orchidectomy as treatment for testicular or other urological cancer, subject to applicable cost sharing consistent with cost-sharing established for other plan benefits.
- Physical complications of all stages of orchiectomy or orchidectomy. (Benefits for surgical reconstruction resulting from these treatments are covered under *Reconstructive Procedures*.

## 30. Temporomandibular and Craniomandibular Joint Services

Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ) and craniomandibular joint (CMJ) disorders and associated muscles.

Diagnosis: Examination, radiographs, and applicable imaging studies and consultation.

Non-surgical treatment, including clinical examinations, oral appliances (orthotic splints), arthrocentesis, and trigger-point injections.

Benefits are provided for surgical treatment if the following criteria are met:

- There is clearly demonstrated radiographic evidence of significant joint abnormality.
- Non-surgical treatment has failed to adequately resolve the symptoms.
- Pain or dysfunction is moderate or severe.

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy and open or closed reduction of dislocations.

Benefits under this section include coverage of temporomandibular joint and craniomandibular jaw disorders as required by Kentucky law.

## 31. Therapeutic Treatments - Outpatient

Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services.*

## 32. Transplantation Services

Organ and tissue transplants when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include bone marrow, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel, cornea and treatment of breast cancer by high-dose chemotherapy with autologous bone marrow or stem cell transplant.

Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Policy.

For Network Benefits, transplantation services must be received at a Designated Facility.

## 33. Urgent Care Center Services

Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services - Sickness and Injury.*

## 34. Wigs

Benefits for the first wig following cancer treatment.

## 35. Endometrioses and Endometritis

Benefits for the diagnosis and treatment of endometriosis and endometritis.

## 36. Inborn Errors of Metabolism or Genetic Conditions

Therapeutic Food, Formulas and Supplements and Low Protein Modified Foods if they are obtained for the therapeutic treatment of inborn errors of metabolism or genetic conditions and are administered under the direction of a Physician.

Benefits for Low Protein Modified Foods and Therapeutic Food, Formulas and Supplements for the therapeutic treatment of inborn errors of metabolism or genetic conditions are provided as described in *Section 4: Outpatient Prescription Drug Products.*

## 37. Telehealth or Digital Health

Covered Health Services provided through telehealth rather than face-to-face consultation when the services can appropriately be provided through telehealth.

For the purpose of this Benefit, “telehealth or digital health” means a mode of delivering healthcare services through the use of telecommunication technologies, including but not limited to synchronous and asynchronous technology, remote patient monitoring technology, and audio-only encounter, by a health care provider to a patient or to another health care provider at a different location.

Telehealth or digital health does not include :

- delivery of health services through electronic mail, text chat, or facsimile unless a state agency authorized or required to promulgate administrative regulations relating to telehealth determines that health care services can be delivered via these modalities in ways that enhance recipient health and well-being and meet all clinical and technology guidelines for recipient safety and appropriate delivery of services; or
- basic communication between a health care provider and a patient, including but not limited to appointment scheduling, appointment reminders, voicemails, or any other similar communication intended to facilitate the actual provision of healthcare services wither in-person or via telehealth.

Benefits are available on the same basis as similar services that are not received through telehealth.

## 38. Iatrogenic Infertility Services

Benefits for the purpose of fertility preservation services when a medically necessary treatment may directly or indirectly cause iatrogenic infertility. The required coverage includes evaluation expenses, laboratory assessments, and treatments associated with oocyte and sperm cryopreservation procedures, including first year storage costs. This benefit mandate will not apply to employer-sponsored health benefit plans if the employer is a religious organization.

# Section 2: Exclusions and Limitations

## How Headings Are Used in this Section

To help the insured find specific exclusions more easily, the carrier uses headings (for example *A. Alternative Treatments* below). The headings group services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath headings. A heading does not create, define, modify, limit or expand an exclusion. All exclusions in this section apply to the insured.

## The carrier does not Pay Benefits for Exclusions

The carrier will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for the insured's condition.

The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in *Section 1: Covered Health Services*.

## Benefit Limitations

When Benefits are limited within any of the Covered Health Service categories described in *Section 1: Covered Health Services,* those limits are stated in the corresponding Benefit description. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. Please review all limits carefully, as the carrier will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

*Please note that in listing services or examples, when stating "this includes," the intent is to limit the description to that specific list. When the intent is to limit a list of services or examples, it is stated specifically that the list "is limited to."*

## A. Alternative Treatments

1. Acupressure and acupuncture.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM)* of the *National Institutes of Health.* This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in *Section 1: Covered Health Services.*

## B. Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia).

   This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Coverage - Accident Only* under *Section 1: Dental Services* and *Section 5: Pediatric Dental Services.*

This exclusion does not apply to dental care (oral examination, X-rays, extractions, and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Policy, limited to:

- Transplant preparation.
- Prior to the initiation of immunosuppressive drugs.
- The direct treatment of acute traumatic Injury, cancer or cleft palate.

Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery, and restorative treatment are excluded.

2. Preventive care (other than those explicitly covered), diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:

   - Extraction, restoration, and replacement of teeth.
   - Medical or surgical treatments of dental conditions.
   - Services to improve dental clinical outcomes.

   This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Section 1, Dental Coverage - Accident Only* or to pediatric Dental Services for which the Benefits are provided as described under *Section 5: Pediatric Dental Services*.

3. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Section 1, Dental Coverage – Accident Only* or to pediatric Dental Services for which Benefits are provided as described under *Section 5: Pediatric Dental Services*.

4. Dental braces (orthodontics). This exclusion does not apply to pediatric Dental Services for which Benefits are provided as described under *Section 5: Pediatric Dental Services*.

5. Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly. This exclusion does not apply to pediatric Dental Services for which Benefits are provided as described under *Section 5: Pediatric Dental Services*.

## C. Devices, Appliances and Prosthetics

1. Devices used specifically as safety items or to affect performance in sports-related activities.

2. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. This exclusion does not apply to orthotic devices for which Benefits are available as described under Orthotic Devices in Section 1: Covered Health Services.

3. Cranial banding.

4. The following items are excluded, even if prescribed by a Physician:

   - Blood pressure cuff/monitor.
   - Enuresis alarm.
   - Non-wearable external defibrillator.
   - Trusses.
   - Ultrasonic nebulizers.

5. Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under Durable Medical Equipment in Section 1: Covered Health Services.
6. Oral appliances for snoring.
7. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect.
8. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

## D. Drugs

Exclusions listed directly below apply to Benefits and services described in *Section 1: Covered Health Services.* These exclusions do not apply to outpatient prescription drug products for which Benefits are available as described in *Section 4: Outpatient Prescription Drug Products.*

1. Prescription drug products for outpatient use that are filled by a prescription order or refill.
2. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by the carrier) must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.
3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.
4. Over-the-counter drugs and treatments.
5. Growth hormone therapy.

## E. Experimental or Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

This exclusion does not apply to Covered Health Services provided during a qualifying clinical trial or cancer clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Services.*

## F. Foot Care

1. Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.
2. Nail trimming, cutting, or debriding.
3. Hygienic and preventive maintenance foot care. Examples include:

    - Cleaning and soaking the feet.
    - Applying skin creams in order to maintain skin tone.

    This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.
4. Treatment of flat feet.
5. Treatment of subluxation of the foot.

6. Shoes. This exclusion does not apply to built-up shoes and therapeutic shoes for Covered Persons with diabetes for which Benefits are available as described under *Orthotic Devices* in *Section 1: Covered Health Services*.

7. Shoe orthotics. This exclusion does not apply to shoe orthotics for which Benefits are available as described under *Orthotic Devices* in *Section 1: Covered Health Services*.

8. Shoe inserts. This exclusion does not apply to custom-made shoe inserts for which Benefits are available as described under *Orthotic Devices* in *Section 1: Covered Health Services*.

9. Foot support devices, including arch supports and corrective shoes, unless they are an integral part of a leg brace. This exclusion does not apply to orthotic devices for which Benefits are available as described under *Orthotic Devices* in *Section 1: Covered Health Services*.

## G. Medical Supplies

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:

    - Compression stockings.
    - Ace bandages.
    - Gauze and dressings.
    - Urinary catheters.

    This exclusion does not apply to:

    - Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*.
    - Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.
    - Ostomy supplies for which Benefits are provided as described under *Ostomy Supplies* in *Section 1: Covered Health Services*.

2. Tubings and masks except when used with *Durable Medical Equipment* as described under *Durable Medical Equipment in Section 1: Covered Health Services*.

## J. Nutrition

1. Individual and group nutritional counseling. This exclusion does not apply to preventive care for which Benefits are provided under the United State Preventive Services Task Force or to nutritional counseling services as described under Section 1: Covered Health Care Services. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered healthcare professionals when both of the following are true:

    - Nutritional education is required for a disease in which patient self-management is an important component of treatment.
    - There exists a knowledge deficit regarding the disease, which requires the intervention of a trained health professional.

2. Enteral feedings, even if the sole source of nutrition. This exclusion does not apply to inborn errors of metabolism or genetic conditions for which Benefits are provided as described under *Inborn Errors of Metabolism or Genetic Conditions* in *Section 1: Covered Health Services*.

3. Infant formula and donor breast milk. This exclusion does not apply to inborn errors of metabolism or genetic conditions for which Benefits are provided as described under *Inborn Errors of Metabolism or Genetic Conditions* in *Section 1: Covered Health Services*.

4. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods).

## K. Personal Care, Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/barber service.
4. Guest service.
5. Supplies, equipment and, similar incidental services and supplies for personal comfort. Examples include:

- Air conditioners, air purifiers, and filters, and dehumidifiers.
- Batteries and battery chargers.
- Breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement.
- Car seats.
- Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, and recliners.
- Exercise equipment.
- Home modifications such as elevators, handrails, and ramps.
- Hot tubs.
- Humidifiers.
- Jacuzzis.
- Mattresses.
- Medical alert systems.
- Motorized beds.
- Music devices.
- Personal computers.
- Pillows.
- Power-operated vehicles.
- Radios.
- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Safety equipment.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

## L. Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 3: Defined Terms*. Examples include:

- Pharmacological regimens, nutritional procedures or treatments.
- Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery, and other such skin abrasion procedures).

- Skin abrasion procedures performed as a treatment for acne.
- Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
- Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
- Treatment for spider veins.
- Hair removal or replacement by any means.

2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Services*.
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility and diversion or general motivation.
5. Weight loss programs, whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
6. Wigs, regardless of the reason for the hair loss. This exclusion does not apply to the first wig following cancer treatment for which Benefits are provided as described under *Wigs* in *Section 1: Covered Health Services*.

## M. Procedures and Treatments

1. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).
3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
4. Rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment.
5. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.
6. Psychosurgery.
7. Sex transformation operations and related services.
8. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.
9. Biofeedback.
10. The following services for the diagnosis and treatment of TMJ or CMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; and dental restorations. This exclusion does not apply to treatment of temporomandibular joint syndrome or craniomandibular joint disorders for which Benefits are provided as described under *Temporomandibular and Craniomandibular Joint Services* in *Section 1: Covered Health Services.*
11. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons because of a Congenital Anomaly,

acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea. This exclusion does not apply to treatment of temporomandibular joint syndrome or craniomandibular joint disorders for which Benefits are provided as described under *Temporomandibular and Craniomandibular Joint Services* in *Section 1: Covered Health Services*.

12. Surgical and non-surgical treatment of obesity.
13. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings. This exclusion does not apply to tobacco use screening and counseling as provided under *Preventive Care Services* in *Section 1: Covered Health Services*.
14. Breast reduction surgery except as coverage is required by the Women's Health and Cancer Rights Act of 1998 for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Services*.
15. In vitro fertilization, regardless of the reason for treatment. This exclusion does not apply to Coverage for Iatrogenic Infertility Preservation Services as outlined in *Iatrogenic Infertility* under *Section 1: Covered Health Services.*

## N. Providers

1. Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with the insured's same legal residence.
3. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:

    - Has not been actively involved in the insured's medical care prior to ordering the service, or
    - Is not actively involved in the insured's medical care after the service is received.

This exclusion does not apply to mammography.

## O. Reproduction

1. Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility. This exclusion does not apply to Coverage for Iatrogenic Infertility Preservation Services as outlined in *Iatrogenic Infertility* under *Section 1: Covered Health Services.*
2. Surrogate parenting, donor eggs, donor sperm and host uterus.
3. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.
4. The reversal of voluntary sterilization.

5. Health services and associated expenses for surgical, non-surgical or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage).

## P. Services Provided under another Plan

1. Health services for which workers' compensation is required by federal, state or local law to be purchased or provided through other arrangements.

   Except for any employee exempted from workers' compensation coverage pursuant to KRS 342.650(1), (2), (3), (5) or (7) of *Title XXVII, Labor and Human Rights,* of the *Kentucky Revised Statues*, and the owner or owners of a business, including qualified partners as defined in KRS 342.012(3) of *Title XXVII, Labor and Human Rights,* of the *Kentucky Revised Statues*, if coverage under workers' compensation is optional for the insured because the insured could elect it, or could have it elected for the insured, Benefits will not be paid for any Injury or Sickness that would have been covered under workers' compensation or similar legislation had that coverage been elected.

2. Health services for treatment of military service-related disabilities, when the insured is legally entitled to other coverage and facilities are reasonably available to the insured.

3. Health services while on active military duty.

## R. Transplants

1. Health services for organ and tissue transplants, except those described under *Transplantation Services* in *Section 1: Covered Health Services*.

2. Health services connected with the removal of an organ or tissue from the insured for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.)

3. Health services for transplants involving permanent mechanical or animal organs.

## S. Travel

1. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in *Section 1: Covered Health Services.*

## T. Types of Care

1. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.

2. Custodial Care or maintenance care.

3. Domiciliary care.

4. Private Duty Nursing. This exclusion does not apply to Private Duty Nursing on a home basis for which Benefits are provided as described under *Home Health Care* in Section 1: Covered Health Services. Private Duty Nursing services in an Inpatient setting remain excluded. In addition, Benefits for Private Duty Nursing exclude the following:

- Services provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.
- Services once patient or caregiver is trained to perform care safely.
- Services for the comfort or convenience of the Covered Person or the Covered Person's caregiver.
- Services that are custodial in nature (Custodial Care).
- Intermittent care.

5. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency or to autism treatment for which Benefits are provided as described under *Hospice Care* and *Autism Treatment in Section 1: Covered Health Services*.

6. Rest cures.

7. Services of personal care attendants.

8. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

## U. Vision and Hearing

1. Purchase cost and fitting charge for eyeglasses and contact lenses. This exclusion does not apply to pediatric Vision Care Services for which Benefits are provided as described under *Section 6: Pediatric Vision Care Services*.

2. Routine vision examinations, including refractive examinations to determine the need for vision correction. This exclusion does not apply to pediatric Vision Care Services for which Benefits are provided as described under *Section 6: Pediatric Vision Care Services*.

3. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants). This exclusion does not apply to pediatric Vision Care Services for which Benefits are provided as described under *Section 12: Pediatric Vision Care Services*.

4. Eye exercise or vision therapy. This exclusion does not apply to pediatric Vision Care Services for which Benefits are provided as described under *Section 6: Pediatric Vision Care Services*.

5. Surgery that is intended to allow the insured to see better without glasses or other vision correction. Examples include radial keratotomy, laser, and other refractive eye surgery.

6. Bone-anchored hearing aids except when either of the following applies:

    - For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
    - For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

    More than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled under the Policy.

    Repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage criteria, other than for malfunctions.

## V. All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 3: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which the carrier determines to be all of the following:

    - Medically Necessary, except as explicitly stated medical necessity is not a required determination.
    - Described as a Covered Health Service under *Section 1: Covered Health Services*.
    - Not otherwise excluded under Section 2: Exclusions and Limitations.

2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when:

    - Required solely for purposes of school, sports or camp, travel, career or employment, insurance, marriage or adoption.
    - Related to judicial or administrative proceedings or orders. This exclusion does not apply to a Covered Person who is a prisoner incarcerated in a local or regional penal institution or in the custody of a local or regional law enforcement officer prior to the conviction of a felony.
    - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a qualifying clinical trial or cancer clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Services*.
    - Required to obtain or maintain a license of any type.

3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians Injured or otherwise affected by war, any act of war, or terrorism in non-war zones.

4. Health services received after the date the insured's coverage under the Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date the insured's coverage under the Policy ended. This exclusion does not apply to extended coverage if the insured is being treated as an inpatient or for Total Disability Benefits.

5. Health services for which the insured have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy.

6. In the event a out-of-network provider waives Copayments, Coinsurance, and/or any deductible for a particular health service, no Benefits are provided for the health service for which the Copayments, Coinsurance and/or deductible are waived.

7. Charges in excess of Eligible Expenses or in excess of any specified limitation.

8. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.

9. Autopsy.

10. Foreign language and sign language services.

11. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services the carrier would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

    For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

# Section 3: Defined Terms

**Alternate Facility -** a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Medical Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health Services or Substance Use Disorder Services on an outpatient or inpatient basis.

**Annual Deductible -** for Benefit plans that have an Annual Deductible, this is the amount of Eligible Expenses the insured must pay for Covered Health Services per year before the carrier will begin paying for Benefits. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses.

**Applied Behavioral Analysis -** 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 Spectrum Disorders -** a physical, mental, or cognitive illness or disorder which includes any of the pervasive developmental disorders as defined by the most current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association,* including *Autistic Disorder, Asperger's Disorder,* and *Pervasive Development Disorder Not Otherwise Specified (PDDNOS).*

**Benefits -** the insured's right to payment for Covered Health Services that are available under the Policy. The insured's right to Benefits is subject to the terms, conditions, limitations, and exclusions of the Policy.

**Biomarker –** (1) a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes, or pharmacologic responses to a specific therapeutic intervention, including known gene-drug interactions for medications being considered for use or already being administered; and (2) Includes but it not limited to gene mutations and protein expression.

**Coinsurance -** the charge, stated as a percentage of Eligible Expenses, that the insured is required to pay for certain Covered Health Services.

**Congenital Anomaly -** a physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

**Copayment -** the charge, stated as a set dollar amount, that the insured is required to pay for certain Covered Health Services.

Please note that for Covered Health Services, the insured is responsible for paying the lesser of the following:

- The applicable Copayment.
- The Eligible Expense.

**Cosmetic Procedures -** procedures or services that change or improve appearance without significantly improving physiological function, as determined by the carrier.

**Covered Health Service(s) -** those health services, including services, supplies, or Pharmaceutical Products, which the carrier determines to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service under *Section 1: Covered Health Services*.
- Not otherwise excluded under *Section 2: Exclusions and Limitations*

**Covered Person -** either the Subscriber or an Enrolled Dependent, but this term applies only while the person is enrolled under the Policy. References to "the insured" and "the insured's" throughout this document are references to a Covered Person.

**Custodial Care -** services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

**Dependent -** the Subscriber's legal spouse or a child of the Subscriber or the Subscriber's spouse. The term child includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.

To be eligible for coverage under the Policy, a Dependent must reside within the Service Area or have reasonable access to the Service Area.

The definition of Dependent is subject to the following conditions and limitations:

- A Dependent includes any child listed above under 26 years of age.
- A Dependent includes an unmarried dependent child of any age who is or becomes intellectually or physically disabled and dependent upon the Subscriber.

The Subscriber must reimburse the carrier for any Benefits that the carrier pays for a child at a time when the child did not satisfy these conditions.

A Dependent also includes a child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order, even if the child does not reside within the Service area. The Enrolling Group is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order.*

A Dependent does not include anyone who is also enrolled as a Subscriber. No one can be a Dependent of more than one Subscriber.

**Designated Facility -** a facility that has entered into an agreement with the carrier, or with an organization contracting on the carrier’s behalf, to render Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within the Service Area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated Facility.

**Designated Network Benefits -** for Benefit plans that have a Designated Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by a Physician or other provider that the carrier has identified as Designated Network providers.

**Designated Physician -** a Physician that the carrier has identified through the carrier’s designation programs as a Designated provider. A Designated Physician may or may not be located within the Service Area. The fact that a Physician is a Network Physician does not mean that he or she is a Designated Physician.

**Durable Medical Equipment -** medical equipment that is all of the following:

- Can withstand repeated use.
- Is not disposable.
- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Is appropriate for use, and is primarily used, within the home.
- Is not implantable within the body.

**Eligible Expenses -** for Covered Health Services, incurred while the Policy is in effect, Eligible Expenses are determined by the carrier as stated below.

Eligible Expenses are determined solely in accordance with the carrier's reimbursement policy guidelines. The carrier develops the reimbursement policy guidelines following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that the carrier accepts.

**Emergency -** a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness which manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson would reasonably have cause to believe constitutes a condition that, in the absence of immediate medical attention, could reasonably be expected to result in any of the following:

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

With respect to a pregnant woman who is having contractions:

- A situation where there is inadequate time to safely transfer to another Hospital before delivery.
- A situation in which transfer may pose a threat to the health or safety of the woman or unborn child.

**Emergency Detoxification Treatment -** the systematic treatment undertaken when attempting to remove or counteract the acutely threatening physiological or hypersensitive reaction to alcohol.

**Emergency Medical Services -** a medical screening examination which is within the capability of the emergency department of the Hospital or Alternate Facility, including ancillary services available, to evaluate and provide the treatment required to stabilize the Covered Person. "Stabilize" means to provide treatment that ensures that no material deterioration of the Covered Person's condition is likely to result or occur during the transfer of the Covered Person from the facility.

**Enrolled Dependent -** a Dependent who is properly enrolled under the Policy.

**Enrolling Group -** the employer, or other defined or otherwise legally established group, to whom the Policy is issued.

**Experimental or Investigational Service(s) -** medical, surgical, diagnostic, psychiatric, mental health, substance use disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time the carrier makes a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

  Exceptions:
- Qualifying clinical trials or cancer clinical trials for which Benefits are available as described under *Clinical Trials* in *Section 1: Covered Health Services*.

- If the insured is not a participant in a qualifying clinical trial or cancer clinical trial, as described under *Clinical Trials* in *Section 1: Covered Health Services*, and have a Sickness or condition that is likely to cause death within one year of the request for treatment the carrier may consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, the carrier must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

**Genetic Testing -** examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder.

**Home Health Agency -** a program or organization authorized by law to provide health care services in the home.

**Hospital -** an institution that is operated as required by law and that meets both of the following:

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

**Iatrogenic Infertility** – an impairment or fertility caused by surgery, radiation, chemotherapy, or any other medical treatment affecting reproductive organs or processes.

**Injury -** bodily damage other than Sickness, including all related conditions and recurrent symptoms.

**Inpatient Rehabilitation Facility -** a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

**Inpatient Stay -** an uninterrupted confinement that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

**Intensive Outpatient Treatment -** a structured outpatient mental health or substance use disorder treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

**Intermittent Care -** skilled nursing care that is provided or needed either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in exceptional circumstances when the need for additional care is finite and predictable.

**Low Protein Modified Foods -** a product formulated to have less than one gram of protein per serving and intended for the dietary treatment of inborn errors of metabolism or genetic conditions when administered under the direction of a Physician.

**Manipulative Treatment -** the therapeutic application of chiropractic and/or osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

**Medically Necessary -** means health care services that a provider would render to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or its symptoms in a manner that is: (a) In accordance with generally accepted standards of medical practice; and (b) Clinically appropriate in terms of type, frequency, extent, and duration.

**Medicare -** Parts A, B, C, and D of the insurance program established by Title XVIII, *United States Social Security Act,* as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

**Mental Health Services -** Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

**Mental Health/Substance Use Disorder Designee -** the organization or individual, designated by the carrier, that provides or arranges Mental Health Services and Substance Use Disorder Services for which Benefits are available under the Policy.

**Mental Illness -** those mental health or psychiatric diagnostic categories that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association,* unless those services are specifically excluded under the Policy.

**Network -** when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with the carrier or with the carrier's affiliate to participate in the carrier's Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Shared Savings Program. Insurer affiliates are those entities affiliated with the carrier through common ownership or control with the carrier or with the carrier's ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some of the carrier's products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a out-of-network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

**Network Benefits -** for Benefit plans that have a Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by Network providers.

Network Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider. Emergency Medical Services are always paid as Network Benefits. For facility charges, these are Benefits for Covered Health Services that are billed by a Network facility and provided under the direction of either a Network or out-of-network Physician or other provider. Network Benefits include Physician services provided in a Network facility by a Network or a out-of-network Emergency room Physician, radiologist, anesthesiologist or pathologist.

**Out-of-network Benefits -** for Benefit plans that have a Out-of-network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by out-of-network providers.

Out-of-network Benefits apply to Covered Health Services that are provided by a out-of-network Physician or other out-of-network provider, or Covered Health Services that are provided at a out-of-network facility.

**Out-of-Pocket Maximum -** this is the maximum amount the insured pays every year.

**Partial Hospitalization/Day Treatment -** a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

**Pharmaceutical Product(s) -** *U.S. Food and Drug Administration* (FDA)-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the Policy.

**Pharmaceutical Product List -** a list that categorizes into tiers medications, products or devices that have been approved by the *U.S. Food and Drug Administration (FDA).* This list is subject to the carrier's periodic review and modification (generally quarterly, but no more than six times per calendar year).

**Physician -** any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, licensed ophthalmic dispenser, registered nurse first assistant, surgical first assistant, certified surgical assistant, advanced practice registered nurse, licensed clinical social worker, dentist, physician's assistant, pharmacist, physical therapist, occupational therapist or other health care practitioner who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that the carrier describes a provider as a Physician does not mean that Benefits for services from that provider are available to the insured under the Policy.

**Policy -** the entire agreement issued to the Enrolling Group that includes all of the following:

- The *Group Policy*.

- The *Certificate*.
- The Enrolling Group's application.

These documents make up the entire agreement that is issued to the Enrolling Group.

**Pregnancy -** includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

**Premium -** the periodic fee required for each Subscriber and each Enrolled Dependent, in accordance with the terms of the Policy.

**Primary Physician -** a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice, Manipulative Treatment, optometry, osteopathy or general medicine.

**Private Duty Nursing -** nursing services for Covered Persons who require more individual and continuous care than is available from a visiting nurse through a Home Health Agency. Rather than a nursing service that is 4 hours or less and periodic (and for which Benefits are provided under *Home Health Care* in the *Section 1: Covered Health Services),* the Private Duty Nursing services are provided where longer durations of skilled nursing care for complex medical conditions requiring immediate medical interventions are required and may include shift care or 24/7 continuous cares in certain settings.

**Qualified Health Care Provider -** a person licensed in this state to provide medical care acting within the scope of their practice.

**Residential Treatment Facility -** a facility which provides a program of effective Mental Health Services or Substance Use Disorder Services treatment and which meets all of the following requirements:
It is established and operated in accordance with applicable state law for residential treatment programs.

- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Use Disorder Designee.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
    - Room and board.
    - Evaluation and diagnosis.
    - Counseling.
    - Referral and orientation to specialized community resources.

A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital.

**Semi-private Room -** a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

**Service Area -** the geographic area the carrier serves, which has been approved by the appropriate regulatory agency.

**Sickness -** physical illness, disease or Pregnancy. The term Sickness as used in this document does not include Mental Illness or substance use disorders, regardless of the cause or origin of the Mental Illness or substance use disorder.

**Skilled Nursing Facility -** a Hospital or nursing facility that is licensed and operated as required by law.

**Specialist Physician -** a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice, Manipulative Treatment, optometry, osteopathy or general medicine.

**Subscriber -** an Eligible Person who is properly enrolled under the Policy. The Subscriber is the person (who is not a Dependent) on whose behalf the Policy is issued to the Enrolling Group.

**Substance Use Disorder Services -** Covered Health Services for the diagnosis and treatment of alcoholism and substance use disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association,* unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

**Therapeutic Food, Formulas and Supplements -** a product intended for the dietary treatment of inborn errors of metabolism or genetic conditions when administered under the direction of a Physician.

**Total Disability -** a Subscriber's inability to perform all of the substantial and material duties of his or her regular employment or occupation; and a Dependent's inability to perform the normal activities of a person of like age and sex.

**Transitional Care -** Mental Health Services and Substance Use Disorder Services that are provided through transitional living facilities, group homes, and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment. and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangements which are residences such as transitional living facilities, group homes, and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

**Unproven Service(s) -** services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

The carrier has a process by which the carrier compiles and reviews clinical evidence with respect to certain health services. From time to time, the carrier may issue medical and drug policies that describe the clinical evidence available with respect to specific healthcare services. These medical and drug policies are subject to change without prior notice.

Please note:

- If the insured has a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) the carrier may determine an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, the carrier must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

**Urgent Care Center -** a facility that provides Covered Health Services that are required to prevent serious deterioration of the insured’s health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

# Section 4: Outpatient Prescription Drug Products

This section describes Prescription Drug Products for which Benefits are available. Please refer below for details about:

- Any supply limits that apply to Prescription Drug Products.

## Coverage Policies and Guidelines

The Prescription Drug List (PDL) Management Committee is authorized to make tier placement changes on the carrier's behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including clinical and economic factors. Clinical factors may include evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits should apply. Economic factors may include the Prescription Drug Product's acquisition cost including available rebates and assessments on the cost effectiveness of the Prescription Drug Product.

A specific tier is not limited to specific classes or categories of Prescription Drug Products. Tier 1 represents the lower cost option for the insured and includes many Generic Prescription Drug Products because such Prescription Drug Products often provide the best health care value. Both Brand-name and Generic Prescription Drug Products, however, may be placed in any tier. Tier 2 represents a middle cost option for the insured and includes many Brand-name Prescription Drug Products. Prescription Drug Products placed in a higher tier have a greater cost option for the insured, but Prescription Drug Products in a higher tier generally have a Tier 1 or Tier 2 alternative available.

Some Prescription Drug Products are more cost effective for specific indications as compared to others; therefore, a Prescription Drug Product may be listed on multiple tiers according to the indication for which the Prescription Drug Product was prescribed, or according to whether it was prescribed by a Specialist Physician.

The carrier may periodically change the placement of a Prescription Drug Product among the tiers. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to the insured.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

NOTE: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, the insured may be required to pay more or less for that Prescription Drug Product.

The insured's Physician may request that the carrier authorize payment for a Prescription Drug Product that is not included on the Prescription Drug List. The carrier has a policy through which it may provide Benefits for these Prescription Drug Products.

## Limitation on Selection of Pharmacies

If the carrier determines that the insured may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, the insured's selection of Network Pharmacies may be limited. If this happens, the carrier may require the insured to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if the insured uses the designated single Network Pharmacy. If the insured doesn't make a selection within 31 days of the date the carrier notifies the insured, the carrier will select a single Network Pharmacy for the insured.

## Coupons, Incentives and Other Communications

At various times, the carrier may send mailings to the insured or to the insured's Physician that communicate a variety of messages, including information about Prescription Drug Products. These mailings may contain coupons or offers from pharmaceutical manufacturers that enable the insured, if the insured chooses, to purchase

the described drug product at a discount or to obtain it at no charge. Pharmaceutical manufacturers may pay for and/or provide the content for these mailings. Only the insured's Physician can determine whether a change in the insured's Prescription Order or Refill is appropriate for the insured's medical condition.

## Special Programs

The carrier may have certain programs in which the insured may receive an enhanced Benefit based on the insured's actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs.

## Prescription Drug Products Prescribed by a Specialist Physician

The insured may receive an enhanced Benefit based on whether the Prescription Drug Product was prescribed by a Specialist Physician.

## Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service.

#### Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

If the insured require Specialty Prescription Drug Products, the carrier may direct the insured to a Designated Pharmacy with whom the carrier has an arrangement to provide those Specialty Prescription Drug Products.

Please see *Defined Terms* for a full description of Specialty Prescription Drug Product and Designated Pharmacy.

The following supply limits apply:

- As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.

When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed. Supply limits apply to Specialty Prescription Drug Products obtained at a Network Pharmacy, a out-of-network Pharmacy, a mail order Network Pharmacy, or a Designated Pharmacy.

#### Prescription Drugs from a Retail Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail Network Pharmacy.

The following supply limits apply:

- As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.
- A one-cycle supply of a contraceptive. The insured may obtain up to three cycles at one time if the insured pays a Copayment and/or Coinsurance for each cycle supplied.

When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.

#### Prescription Drug Products from a Mail Order Network Pharmacy

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy.

The following supply limits apply:

- As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. These supply limits do not apply to Specialty Prescription Drug Products. Specialty Prescription Drug Products from a mail order Network Pharmacy are subject to the supply limits stated above under the heading *Specialty Prescription Drug Products*.

To maximize the insured's Benefit, ask the insured's Physician to write the insured's Prescription Order or Refill for a 90-day supply, with refills when appropriate.

## Exclusions for Outpatient Prescription Drug Products

Exclusions from coverage listed in *Section 2: Exclusions and Limitations* apply also to *Section 4: Outpatient Prescription Drug Products,* except that any preexisting condition is not applicable to *Section 4: Outpatient Prescription Drug Products.* In addition, the exclusions listed below apply.

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
3. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
4. Experimental or Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by the carrier to be experimental, investigational or unproven.
5. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
6. Prescription Drug Products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
7. Any product dispensed for the purpose of appetite suppression or weight loss.
8. A Pharmaceutical Product for which Benefits are provided. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
9. Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
10. General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
11. Unit dose packaging of Prescription Drug Products.
12. Medications used for cosmetic purposes.
13. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that the carrier determines do not meet the definition of a Covered Health Service.
14. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.

15. Prescription Drug Products when prescribed to treat infertility. This exclusion does not apply to Coverage for Iatrogenic Infertility Preservation Services as outlined in *Iatrogenic Infertility* under *Section 1: Covered Health Services.*

16. Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and *Drug Administration (FDA)* and requires a Prescription Order or Refill. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier 3.)

17. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the carrier has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that the carrier has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the carrier may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision. This exclusion does not apply to over-the-counter drugs used for smoking cessation.

18. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by the carrier's PDL Management Committee.

19. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).

20. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, except for Therapeutic Food, Formulas, and Supplements, and Low Protein Modified Foods prescribed for the therapeutic treatment of inborn errors of metabolism or genetic conditions.

21. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and the carrier may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

22. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and the carrier may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

23. Certain Prescription Drug Products that have not been prescribed by a Specialist Physician.

## Defined Terms for Prescription Drug Products

The following definitions are in addition to those listed in *Section 3: Defined Terms:*

**Ancillary Charge -** a charge, in addition to the Copayment and/or Coinsurance, that the insured is required to pay when a covered Prescription Drug Product is dispensed at the insured's or the provider's request, when a Chemically Equivalent Prescription Drug Product is available on a lower tier. For Prescription Drug Products

from Network Pharmacies, the Ancillary Charge is calculated as the difference between the Prescription Drug Charge or Maximum Allowable Cost (MAC) List price for Network Pharmacies for the Prescription Drug Product on the higher tier, and the Prescription Drug Charge or Maximum Allowable Cost (MAC) List price of the Chemically Equivalent Prescription Drug Product available on the lower tier. For Prescription Drug Products from out-of-network Pharmacies, the Ancillary Charge is calculated as the difference between the Predominant Reimbursement Rate or Maximum Allowable Cost (MAC) List price for out-of-network Pharmacies for the Prescription Drug Product on the higher tier, and the Predominant Reimbursement Rate or Maximum Allowable Cost (MAC) List price of the Chemically Equivalent Prescription Drug Product available on the lower tier.

**Brand-name -** a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that the carrier identifies as a Brand-name product, based on available data resources including First DataBank, that classify drugs as either brand or generic based on a number of factors. The insured should know that all products identified as a "brand name" by the manufacturer, pharmacy, or the insured's Physician may not be classified as Brand-name by the carrier.

**Chemically Equivalent -** when Prescription Drug Products contain the same active ingredient.

**Designated Pharmacy -** a pharmacy that has entered into an agreement with the carrier or with an organization contracting on the carrier's behalf, to provide specific Prescription Drug Products, including Specialty Prescription Drug Products. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

**Generic -** a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that the carrier identifies as a Generic product based on available data resources including First DataBank, that classify drugs as either brand or generic based on a number of factors. The insured should know that all products identified as "generic" by the manufacturer, pharmacy or the insured's Physician may not be classified as Generic by the carrier.

**Network Pharmacy -** a pharmacy that has:

- Entered into an agreement with the carrier or an organization contracting on the carrier's behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by the carrier as a Network Pharmacy.

**New Prescription Drug Product -** a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is assigned to a tier by the carrier's PDL Management Committee.
- December 31st of the following calendar year.

**Prescription Drug Charge -** the rate the carrier has agreed to pay the carrier's Network Pharmacies, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

**Prescription Drug List -** a list that categorizes into tiers medications, products or devices that have been approved by the *U.S. Food and Drug Administration (FDA).* This list is subject to the carrier's periodic review and modification (generally quarterly, but no more than six times per calendar year).

**Prescription Drug List (PDL) Management Committee -** the committee that the carrier designates for, among other responsibilities, classifying Prescription Drug Products into specific tiers.

**Prescription Drug Product -** a medication, product or device that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Policy, this definition includes:

- Inhalers (with spacers).
- Insulin.
- The following diabetic supplies:

- standard insulin syringes with needles;
- blood-testing strips - glucose;
- urine-testing strips - glucose;
- ketone-testing strips and tablets;
- lancets and lancet devices; and
- glucose monitors.

**Prescription Order or Refill -** the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

**Preventive Care Medications -** the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the cost (without application of any Copayment, Coinsurance, Annual Deductible, Annual Drug Deductible or Specialty Prescription Drug Product Annual Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have, in effect, a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

**Specialty Prescription Drug Product -** Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses.

**Therapeutic Class -** a group or category of Prescription Drug Products with similar uses and/or actions.

**Therapeutically Equivalent -** when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

**Usual and Customary Charge -** the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.

# Section 5: Pediatric Dental Services

This section describes Benefits for Covered Dental Services for which Benefits are available for Covered Persons. Please refer to the section and *Covered Benefits and Limitations* for details about any supply limits that apply to pediatric Dental Services.

Benefits specific to the section *Benefits for Pediatric Dental Services* terminate on the date the Covered Person reaches the age of 21.

## Benefits for Pediatric Dental Services

Benefits are provided for the Dental Services, as described below, for Covered Persons under the age of 21, when such services are:

A. Necessary.
B. Provided by or under the direction of a Dental Provider.
C. Clinical situations that can be effectively treated by a less costly, dental appropriate alternative procedure will be assigned a Benefit based on the least costly procedure.
D. Not excluded as described below under Exclusions for Pediatric Dental Services.

**Network Benefits:**

Benefits for Eligible Dental Expenses are determined as a percentage of the negotiated contract fee between the carrier and the provider rather than a percentage of the provider's billed charge. The insurer's negotiated rate with the provider is ordinarily lower than the provider's billed charge.

A Network provider cannot charge the insured or the carrier for any service or supply that is not Necessary as determined by the carrier. If the insured agree to receive a service or supply that is not Necessary, the Network provider may charge the insured. However, these charges will not be considered Covered Dental Services, and Benefits will not be payable.

**Out-of-network Benefits:**

Benefits for Eligible Dental Expenses from out-of-network providers are determined as a percentage of the Usual and Customary fees. The insured must pay the amount by which the out-of-network provider's billed charge exceeds the Eligible Dental Expense.

**Covered Dental Services**

The insured are eligible for Benefits for Covered Dental Services listed under *Covered Benefits and Limitations* below if such Dental Services are Necessary and are provided by or under the direction of a Network Dental Provider.

Benefits are available only for Necessary Dental Services. The fact that a Dental Provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment, for a dental disease does not mean that the procedure or treatment is a Covered Dental Service.

**Covered Benefits and Limitations**

*Diagnostic Services*, inclusive of the following limits:

- Intraoral Bitewing Radiographs (Bitewing X-ray) – Limit of 4 films per 12 months
- Intra-Extraoral X-rays – Limit of 2 films per 12 months
- Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) – Limit of 1 per 12 months
- Periodic Oral Evaluation (Check up Exam) – Limit of 2 per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.

*Preventative Services*, inclusive of the following limits:

- Dental Prophylaxis (Cleaning) – Limit of 2 per 12 months.

- Fluoride Treatments – Limited to Covered Persons under the age of 21. Limit of 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.
- Sealants (Protective Coating) – Limited to Covered Persons under the age of 21. Limited to once per first or second permanent molar every 36 months.

*Space Maintainers*, inclusive of the following limits:

- Space Maintainers (Spacers) – Limited to Covered Persons under the age of 21. Limits to 2 per 12 months. Benefit includes all adjustments made within 6 months of installation.

*Minor Restorative Services, Endodontics, Periodontics and Oral Surgery*, inclusive of the following limits:

- Amalgam Restorations (Silver Filings) – Multiple restorations on one surface will be treated as a single filling.
- Composite Resin Restorations (Tooth Colored Fillings) – For anterior (front) teeth only. Multiple restorations on one surface will be treated as a single filling.
- Endodontics (Root Canal Therapy) – Limited to 1 time per tooth per lifetime.
- Periodontal Surgery (Gum Surgery) – Limited to 1 time per quadrant per 12 months.
- Scaling and Root Planing (Deep Cleanings) – Limits to 1 time per quadrant per 12 months.
- Periodontal Maintenance (Gum Maintenance) – Limited to 2 times per 12 month period following active and adjunctive periodontal therapy within the prior 24 months, exclusive of gross debridement.
- Simple Extractions (Simple Tooth Removal) – Limited to 1 time per tooth per lifetime.
- Oral Surgery, including Surgical Extraction

*Adjunctive Services*, inclusive of the following limits:

- General Services (including Emergency Treatment) – Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guard limited to 1 guard every 12 months.

*Major Restorative Services*, inclusive of the following limits:

- Inlays/Onlays/Crowns (Partial to Full Crowns) – Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.
- Fixed Prosthetics (Bridges) – Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.
- Removable Prosthetics (Full or Partial Dentures) – Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.
- Relining and Rebasing Dentures – Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.
- Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges or Crowns – Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6 months.

*Implants*, inclusive of the following limits:

- Implant Placement – Limited to 1 time per 60 months.
- Implant Supported Prosthetics – Limited to 1 time per 60 months.
- Implant Maintenance Procedures – Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per tooth per 60 months.
- Repair Implant Supported Prosthesis by Report – Limited to 1 time per tooth per 60 months.
- Abutment Supported Crown Titanium) or Retainer Crown for FPD – Titanium – Limited to 1 time per tooth per 60 months.
- Repair Implant Abutment by Support – Limited to 1 time per tooth per 60 months.
- Radiographic/Surgical Implant Index by Report – Limited to 1 time per tooth per 60 months.

*Medically Necessary Orthodontics*, inclusive of the following limits:

Benefits for comprehensive orthodontic treatment are approved by the carrier, only in those instances that are related to an identifiable syndrome such as cleft lip and/or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by the carrier's dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies..

Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.

- Orthodontic Services – Services or supplied furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.

**Pediatric Dental Services - Exclusions**

Except as may be specifically provided under *Benefits for Pediatric Dental Services* and *Covered Benefits and Limitations* above*,* Benefits are not provided within this document for the following:

1. Any Dental Service or Procedure not listed as a Covered Dental Service under *Benefits* in the *Covered Benefits and Limitations* .
2. Dental Services that are not Necessary.
3. Hospitalization or other facility charges.
4. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
5. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, Injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.
6. Any Dental Procedure not directly associated with dental disease.
7. Any Dental Procedure not performed in a dental setting.
8. Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the *American Dental Association (ADA) Council on Dental Therapeutics*. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.
9. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
10. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
11. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
12. Replacement of complete dentures, fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.

13. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint. This exclusion does not apply to treatment of temporomandibular joint syndrome or craniomandibular joint disorders for which Benefits are provided as described under Temporomandibular and Craniomandibular Joint Services in Section 1: Covered Health Services.
14. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours' notice.
15. Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled for coverage provided under this document.
16. Dental Services otherwise covered under the Policy, but rendered after the date individual coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy terminates.
17. Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.
18. Foreign Services are not covered unless required as an Emergency.
19. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
20. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
21. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
22. Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service.
23. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
24. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability. This exclusion does not apply to fixed partial dentals required due to dental disease for which Benefits are provided under *Benefits* in the *Covered Benefits and Limitations*.
25. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
26. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan. This exclusion does not apply to space maintainers for which Benefits are provided under *Space Maintainers* or lost or broken retainers for which Benefits are provided under *General Services* in the *Covered Benefits and Limitations* or to the treatment of temporomandibular joint syndrome or craniomandibular joint disorders for which Benefits are provided under *Temporomandibular or Craniomandibular Joint Services* in *Section 1: Covered Health Benefits*.

# Claims for Dental Services

When obtaining Dental Services from a out-of-network provider, the insured will be required to pay all billed charges directly to the insured's Dental Provider. The insured may then seek reimbursement from the carrier. When the insured submits the claim, the insured must provide the carrier with all of the information identified below.

# Reimbursement for Dental Services

The insured is responsible for sending a request for reimbursement to the carrier's office, on a form provided by or satisfactory to the carrier.

**Claim Forms. It** is not necessary to include a claim form with the proof of loss. However, the proof must include all of the following information:

- Covered Person's name and address.
- Covered Person's identification number.
- The name and address of the provider of the service(s).
- A diagnosis from the Dental Provider, including a complete dental chart showing extractions, fillings, or other dental services rendered before the charge was incurred for the claim.
- Radiographs, lab or hospital reports.
- Casts, molds or study models.
- Itemized bill which includes the *CPT* or *ADA* codes or description of each charge.
- The date the dental disease began.
- A statement indicating that the insured is or the insured is not enrolled for coverage under any other health or dental insurance plan or program. If the insured is enrolled for other coverage the insured must include the name of the other carrier(s).

# Defined Terms for Dental Services

The following definitions are in addition to those listed in *Section 3: Defined Terms*, and apply for both Adult and Pediatric Dental Services*:*

**Covered Dental Service -** a Dental Service or Dental Procedure for which Benefits are provided under *Section 5: Dental Services.*

**Dental Provider -** any dentist or dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to render Dental Services, perform dental surgery or administer anesthetics for dental surgery.

**Dental Service or Dental Procedures -** dental care or treatment provided by a Dental Provider to a Covered Person while the Policy is in effect, provided such care or treatment is recognized by the carrier as a generally accepted form of care or treatment according to prevailing standards of dental practice.

**Eligible Dental Expenses -** Eligible Dental Expenses for Covered Dental Services, incurred while the Policy is in effect, are determined as stated below:

- For Network Benefits, when Covered Dental Services are received from Network Dental Providers, Eligible Dental Expenses are the carrier's contracted fee(s) for Covered Dental Services with that provider.
- For Out-of-network Benefits, when Covered Dental Services are received from Out-of-network Dental Providers, Eligible Dental Expenses are the Usual and Customary fees, as defined below.

**Necessary -** Dental Services and supplies under *Section 5: Dental Services* which are determined by the carrier through case-by-case assessments of care based on accepted dental practices to be appropriate and are all of the following:

- Necessary to meet the basic dental needs of the Covered Person.
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Service.

- Consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted by the carrier.
- Consistent with the diagnosis of the condition.
- Required for reasons other than the convenience of the Covered Person or his or her Dental Provider.
- Demonstrated through prevailing peer-reviewed dental literature to be either:
  - Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or
  - Safe with promising efficacy
    - For treating a life threatening dental disease or condition.
    - Provided in a clinically controlled research setting.
    - Using a specific research protocol that meets standards equivalent to those defined by the *National Institutes of Health*.

(For the purpose of this definition, the term life threatening is used to describe dental diseases or sicknesses or conditions, which are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a Dental Provider has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular dental disease does not mean that it is a Necessary Covered Dental Service as defined under *Defined Terms for Pediatric Dental Services.* The definition of Necessary used in *Section 5: Dental Services* relates only to Benefits under that section and differs from the way in which a Dental Provider engaged in the practice of dentistry may define necessary.

**Usual and Customary -** Usual and Customary fees are calculated by the carrier based on available data resources of competitive fees in that geographic area.

Usual and Customary fees must not exceed the fees that the provider would charge any similarly situated payor for the same services.

Usual and Customary fees are determined solely in accordance with the carrier's reimbursement policy guidelines. The Insurer's reimbursement policy guidelines are developed by the carrier following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology* (publication of the *American Dental Association*).
- As reported by generally recognized professionals or publications.
- As utilized for Medicare.
- As determined by medical or dental staff and outside medical or dental consultants.
- Pursuant to other appropriate sources or determinations that the carrier accepts.

# Section 6: Pediatric Vision Care Services

This section describes Benefits for Covered Vision Care Services for which Benefits are available for Covered Persons under the age of 21. Please refer to the *Covered Benefits and Limitations* section for details about:

- Any supply limits that apply to pediatric Vision Care Services.

Benefits under *Section 6: Pediatric Vision Care Services* terminate on the date the Covered Person reaches the age of 21.

## Routine Vision Examination

A routine vision examination of the condition of the eyes and principal vision functions according to the standards of care in the jurisdiction in which the insured resides, including:

- A case history that includes chief complaint and/or reason for examination, patient medical/eye history, and current medications.
- Recording of monocular and binocular visual acuity, far and near, with and without present correction (for example, 20/20 and 20/40).
- Cover test at 20 feet and 16 inches (checks eye alignment).
- Ocular motility, including versions (how well eyes track) near point convergence (how well eyes move together for near vision tasks, such as reading), and depth perception.
- Pupil responses (neurological integrity).
- External exam.
- Retinoscopy (when applicable) - objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.
- Phorometry/Binocular testing - far and near: how well eyes work as a team.
- Tests of accommodation and/or near point refraction: how well the insured sees at near point (for example, reading).
- Tonometry, when indicated: test pressure in eye (glaucoma check).
- Ophthalmoscopic examination of the internal eye.
- Confrontation visual fields.
- Biomicroscopy.
- Color vision testing.
- Diagnosis/prognosis.
- Specific recommendations.

Post examination procedures will be performed only when materials are required.

Or, in lieu of a complete exam, Retinoscopy (when applicable) - objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.

### Eyeglass Lenses

Lenses that are mounted in eyeglass frames and worn on the face to correct visual acuity limitations.

The insured are eligible to select only one of either eyeglasses *(Eyeglass Lenses* and/or *Eyeglass Frames)* or *Contact Lenses.* If the insured selects more than one of these Vision Care Services, the carrier will pay Benefits for only one Vision Care Service.

**Optional Lens Extras**

Eyeglass Lenses. The following Optional Lens Extras are covered in full:

- Standard scratch-resistant coating.
- Polycarbonate lenses.

### Eyeglass Frames

A structure that contains eyeglass lenses, holding the lenses in front of the eyes and supported by the bridge of the nose.

The insured is eligible to select only one of either eyeglasses *(Eyeglass Lenses* and/or *Eyeglass Frames)* or *Contact Lenses.* If the insured selects more than one of these Vision Care Services, the carrier will pay Benefits for only one Vision Care Service.

### Contact Lenses

Lenses worn on the surface of the eye to correct visual acuity limitations.

Benefits include the fitting/evaluation fees and contacts. The insured is eligible to select only one of either eyeglasses *(Eyeglass Lenses* and/or *Eyeglass Frames)* or *Contact Lenses.* If the insured selects more than one of these Vision Care Services, the carrier will pay Benefits for only one Vision Care Service.

### Necessary Contact Lenses

Benefits are available when a Vision Care Provider has determined a need for and has prescribed the contact lens. Such determination will be made by the Vision Care Provider and not by the carrier.

Contact lenses are necessary if the insured has any of the following:

- Keratoconus.
- Anisometropia.
- Irregular corneal/astigmatism.
- Aphakia.
- Facial deformity.
- Corneal deformity.

### Covered Benefits and Limitations

- Routine Vision Examination or Refraction (only in lieu of a complete exam) – Once every 12 months.
- Eyeglass Lenses – Once every 12 months.
- Eyeglass Frames – Once every 12 months.
- Contact Lens Fitting and Evaluation – Once per year.
- Contact Lenses – Once every 12 months.

## Exclusions for Pediatric Vision Care Services

Except as may be specifically provided under *Routine Vision Examination* and *Covered Benefits and Limitations* above, Benefits are not provided under *Section 6: Pediatric Vision Care Services* for the following:

1. Medical or surgical treatment for eye disease which requires the services of a Physician and for which Benefits are available as stated under *Section 1: Covered Health Services*.
2. Non-prescription items (e.g. Plano lenses).
3. Replacement or repair of lenses and/or frames that have been lost or broken. This exclusion does not apply to coverage provided when the replacement or repair is medically necessary and there is:

- a .50 diopter or more change in prescription.
- a shift in axis of astigmatism of 15 percent or more.
- a difference in vertical prism greater than one prism diopter.

4. Optional Lens Extras not listed under *Routine Vision Examinations* above.
5. Missed appointment charges.
6. Applicable sales tax charged on Vision Care Services.

## Claims for Pediatric Vision Care Services

When obtaining Vision Care Services from a out-of-network Vision Care Provider, the insured will be required to pay all billed charges directly to the insured's Vision Care Provider. The insured may then seek reimbursement from the carrier. When the insured submits the claim, the insured must provide the carrier with all of the information identified below.

### Reimbursement for Vision Care Services

To file a claim for reimbursement for Vision Care Services rendered by a out-of-network Vision Care Provider, or for Vision Care Services covered as reimbursements (whether or not rendered by an in-Network Vision Care Provider or a out-of-network Vision Care Provider), the insured must provide all of the following information on a claim form acceptable to the carrier:

- The insured's itemized receipts.
- Covered Person's name.
- Covered Person's date of birth.

## Defined Terms for Pediatric Vision Care Services

The following definitions are in addition to those listed in *Section 3: Defined Terms:*

**Covered Contact Lens Selection -** a selection of available contact lenses that may be obtained from an In-Network Vision Care Provider on a covered-in-full basis, subject to payment of any applicable Copayment.

**Vision Care Provider -** any optometrist, ophthalmologist, optician or other person who may lawfully provide Vision Care Services.

**Vision Care Service -** any service or item listed under *Routine Vision Examination* and *Covered Benefits and Limitations* sections above.