A STANDARD HEALTH CARE BENEFIT PLAN

A BASIC POLICY THAT REWARDS QUALITY AND PREVENTION

EXCLUSIONS

This health benefit plan provides access to care for basic, core benefits and does not cover the following:

A. General Exclusions

1. Health care services that are not Medically Necessary for the treatment of an illness or injury.

2. Health care services that are Experimental or Investigative, other than services and products associated with childhood cancer therapies and protocols.

3. Health care services provided when the member's coverage was not effective under this plan. This includes health care services provided either prior to the member's effective coverage date or after the member's coverage terminated under this policy.

4. Professional services not provided by a physician or any of the health care providers listed in the definition of Health Care Provider.

5. Health care services provided by a member of a covered individual's immediate family, or anyone else living with him/her

6. Health care services provided in connection with a health care service not covered under this policy. An example would be inpatient hospital services in connection with a health care service not covered under this policy.

B. Other Administrative Exclusions

7. Health care services provided solely for educational or vocational training, other than Graduate Medical Educational (GME) settings.

8. Health care services covered by Medicare, if a member has or is eligible for Medicare, to the extent benefits are or would be available from Medicare, except for such health care services for which under applicable federal law this policy is the primary payer and Medicare is the secondary payer.

9. Health care services furnished by the U.S. Veterans Administration, except for such health care services for which under applicable federal law this policy is the primary payer and the U.S. Veterans Administration is the secondary payer.

10. Health care services furnished by any federal or state agency or local political subdivision when the member is not liable for the costs in the absence of insurance, unless such coverage under this policy is required by any state or federal law.

11. Health care services for any injury or illness caused by: (1) atomic or thermonuclear explosion or resulting radiation; or (2) any type of military action, friendly or hostile.

12. Health care services provided while held, detained, or imprisoned in a local, state, or federal penal or correctional institution or while in the custody of law-enforcement officials, except as specifically stated in State Statutes. Persons on work release are not considered to be held, detained, or imprisoned if they are otherwise eligible members.

13. Third party ordered treatment or testing.

14. Health care services received outside the United States, Canada, Puerto Rico, or the U.S. Virgin Islands, except in an emergency.

15. Custodial care or rest care.

16. Health care services not supported by information contained in the covered individual's medical records or from other relevant sources.

17. Telephone, computer or Internet consultations between a member and any health care provider.

18. Completion of claim forms or forms necessary for a member's return to work or school.

19. Charges for an appointment a member did not attend.

20. Health care services for which proof of claim is not provided to the Plan within 120 days or 1 year if a person is incapacitated.

21. Sales tax or any other tax, levy, or assessment by any federal or state agency or local political subdivision.

22. Health care services not related to an illness or injury, other than as specifically stated in this policy.

C. Specific Procedure Exclusions

23. Health care services for, or used in connection with, transplants of human and non–human parts, tissues or substances, implants of artificial or natural organs or any complications of such transplants or implants, unless otherwise indicated under Summary of Services.

24. Cosmetic treatments or cosmetic surgery.

25. Reconstructive surgery, except for such surgery required:
    (1) to repair a significant defect caused by an injury or illness occurring when the member is covered under this policy; or
    (2) to repair a defect caused by a congenital anomaly causing a functional impairment of a dependent child; or
    (3) as a result of a covered mastectomy; or
    (4) due to a physical illness.

26. Health care services for obesity, weight reduction, dietetic control, or morbid obesity, except when Medically Necessary.

27. Reversal of sterilization procedures.

28. Abortion procedures for the termination of pregnancy, except for risks to a mother's health.

29. Artificial insemination or fertilization methods including, but not limited to, in vivo and in vitro fertilization, embryo transfer, gamete intra fallopian transfer (GIFT) and similar procedures and related hospital, professional and diagnostic services and medications that are incidental to such insemination or fertilization methods.

30. Treatment, services and supplies, including, but not limited to, surgical services, devices and drugs for, or used in connection with, sexual dysfunction, including but not limited to impotence, or for the purpose of enhancing or affecting sexual performance, regardless of whether the origin of the sexual dysfunction is organic or psychological in nature, including, but not limited to, Viagra, Caverject, MUSE, Yohimbine, Femprox or their generic equivalent, penile implants, and sex therapy.

31. Health care services for adults that are associated with sex transformation surgery, the sex transformation surgery, and sex hormones related to such surgery; excepting corrections of birth defects.

32. Health care services provided: (1) in the examination, treatment or removal of all or part of corns, callosities, hypertrophy or hyperplasia of the skin or subcutaneous tissues of the feet; (2) in the cutting, trimming or other non–operative partial removal of toenails; (3) in connection with any of those conditions specified in (1) and (2); except in patients with diabetes, peripheral vascular disease, or neuropathy when Medically Necessary.

33. Health care services provided in connection with the temporomandibular joint, or TMJ syndrome, except for diagnosis and non-surgical treatment.

34. All oral surgeries are excluded, except for the following covered services: (a) Surgical removal of bony impacted teeth; (b) Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth, or surgical procedures to correct injuries to these structures; (c) Excision of exostoses of the jaws and hard palate; (d) Frenotomy; (e) Incision and drainage of cellulitis or abscess of the mouth; and (f) Incision of accessory sinuses, salivary glands or ducts.

D. Specific Diagnostic and Treatment Exclusions

35. Indirect services provided by health care providers for services such as, but not limited to: creating of a laboratory's standards, procedures, and protocols; calibrating equipment; supervising the testing; setting up parameters for test results; and reviewing the quality assurance data.

36. Therapy and testing for treatment of symptoms of allergy/hypersensitivity, unless such therapy or testing is approved by the American Academy of Allergy, Asthma and Immunology.

E. Exclusions for Specific Ancillary Services

37. Dental treatments, services, procedures, drugs, medicines, devices, and/or supplies are not included, unless provided as part of a preventative dental care health management program.

38. Preparation, fitting or purchase of eyeglasses or contact lenses, or vision therapies, unless Medically Necessary.

39. Outpatient physical, speech, occupational, and respiratory therapy, when performed in the home is not covered, unless given by a Certified provider, and only when the attending physician certifies that: (a) hospitalization or confinement in a licensed skilled nursing facility may become necessary if the member did not have said home care therapy; and/or (b) members of the covered member's immediate family, or others living with the member, are unable to provide him/her the medically necessary care and treatment without undo hardship.

40. Charges for health clubs or health spas, aerobic or strength conditioning, work-hardening programs and all related material and products for these programs.

41. Therapy services such as recreational therapy, educational therapy, and physical fitness or exercise programs unless otherwise indicated under Summary of Services.

42. Health education, marriage counseling, holistic medicine, or other programs with an objective to provide complete personal fulfillment.

43. Sleep therapy, massage therapy, or unproven non-evidence based alternative services or treatments.

44. Housekeeping, shopping, or meal preparation services.

F. Specific Medication or Durable Medical Equipment Exclusions

45. Over-the-counter medications, except at the discretion of the insurance entity.

46. Topical applications for treatment of baldness, unless Medically Necessary.

47. Medications, drugs, or hormones to stimulate human biological growth, unless there is a laboratory–confirmed physician's diagnosis of the member's growth hormone deficiency.

48. Occupationally related immunizations.

49. Food received on an outpatient basis, food supplements, or vitamins.

50. Medical supplies and durable medical equipment for the member's comfort, personal hygiene or convenience, including, but not limited to: air conditioners; air cleaners; humidifiers; physical fitness equipment; physician's equipment; disposable supplies, other than colostomy supplies; or self–help devices not medical in nature.

51. Motorized vehicles or durable medical equipment, unless Medically Necessary.

52. Treatment of weak, strained, flat, unstable, or unbalanced feet; arch supports; heel wedges; lifts; orthopedic shoes; or the fitting of orthotics to aid walking or running.

53. Wigs, prosthetic hairpieces, hair transplants, or hair implants.

DEFINITIONS

1. Medically Necessary

Health care that is "medically necessary" refers to a service that is required to prevent, identify, diagnose, or treat a covered individual's illness, injury, or disability, and meets the following standards:

a. Is consistent with the recipient's symptoms or with prevention, diagnosis, or treatment of the recipient's illness, injury, or disability.

b. Is provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider, and the setting in which the service is provided.

c. Is appropriate with regard to generally accepted standards of medical practice.

d. Is not medically contraindicated with regard to the recipient's symptoms or other medically necessary services being provided to the covered individual.

e. Is of proven medical value or usefulness and is not experimental in nature.

f. Is not duplicative with respect to other services being provided to the recipient.

g. Is not solely for the convenience of the recipient's family, or a provider.

h. With respect to prior authorization of a service and to other prospective coverage determinations made by the Medical Director, is cost-effective compared to an alternative medically necessary service, and is reasonably accessible to the recipient.

i. Is the most appropriate supply or level of service that can safely and effectively be provided to the recipient.

2. Experimental or Investigative Health Care Services

Any procedure, treatment, supply, device, equipment, facility, or drug determined by the Medical Director, or his or her designee, NOT to be (a) A proven and effective treatment for the condition for which it is intended or used; or (b) Have final approval from the appropriate government regulatory body; or (c) Have the scientific evidence published in peer-reviewed literature that permits conclusions concerning the effect of the technology on health outcomes; or (d) Improve the net health outcome; or (e) Be as beneficial as any established alternative; or (f) Show improvement outside the investigational settings.

3. Health Care Provider

“Health care provider” is a state licensed health care professional, a health care facility, or a health care service or organization licensed to provide medical services by the appropriate state licensing agency or board.

4. Prior Authorization Procedure

“Prior authorization” means the written authorization issued by the financially responsible party prior to the receipt of a service.

5. Cosmetic Treatment

“Cosmetic treatment” means a treatment performed solely for the sake of appearance where no functional impairment exists.

SUMMARY OF COVERED SERVICES

Each and every health care plan offered for sale anywhere in these United States must openly disclose limits for the following:

A. PLAN-SPECIFIC AGREEMENTS

1. Deductible Option (Individual or Family) $_____
2. Coinsurance $_____
3. Annual Coinsurance Limit $_____
   (the annual maximum amount of covered charges for which a covered individual pays coinsurance; then the plan would pay 100%)
4. Participant Lifetime Maximum Benefit $_____

B. STANDARD SERVICES COVERED (Must be Evidence-Based)

1. Preventative Services as Medically Necessary, or as stated in the U.S. Preventive Services Task Force recommendations:
   - Immunizations approved by the Center for Disease Control's Advisory Committee on Immunization Practices and/or American Academy of Pediatrics (except immunizations required for travel or work)
   - Well–Baby Care to Age 6 (includes routine office visits, check-ups, labs, and Medically Necessary diagnostic procedures)
   - Mammograms, Pap Tests, Colonoscopies, Lung Function Studies and other Preventative Screening Studies approved by Medical Practice Guidelines
   - Blood Lead Level Tests (to Age 5)
2. Hospital Services:
   - Semi-Private Room & Board, Miscellaneous Hospital Expenses, Intensive Care Unit Care and Services
   - Ambulatory Surgery (same day) Fees
   - Outpatient Facility Fees
   - Outpatient Radiology (including interventional), Pathology and Lab Services
3. Emergency Services
   - Emergency Room (facility charge)
   - Emergency Room Care (including Physician Charges and Miscellaneous Expenses)
   - Ambulance Services Ground or air up to $2,000 per trip (Prior approval required for non–emergency transport).

4. Professional Services:
   - Office Visits
   - Maternity Services (prenatal, delivery, and postnatal care including complications of pregnancy)
   - Medical and Surgical Services
   - Corneal Transplants, Bone and Skin Grafts
   - Rehabilitative Therapy up to 40 visits (Occupational, Physical, Speech, Respiratory)
   - Radiation and Chemotherapy Services
   - Cardiac Rehabilitation (up to 48 sessions)
   - Infertility (diagnostic procedures only)
   - Oral Surgery and Dental Repair (due to an injury)
   - X–rays, MRI scans, CT scans, and Laboratory Services
   - Independent Anesthesiologist, Pathologist, and Radiologist Services

5. Home Health Care:
   - Home Health Services (up to 40 visits per year)
   - Home Intravenous Therapy and Supplies (Prior approval required)

6. Health Care Services
   - Breast Reconstruction (following covered mastectomy)
   - Diabetic Equipment, Supplies, and Self–Management Educational Programs
   - Temporomandibular Joint (TMJ) Disorders (diagnostic and non–surgical treatment)
   - Skilled Nursing Care (up to 30 days per confinement; Prior approval required)
   - Durable Medical Equipment and supplies (Medically necessary)

7. Hospice Care Services.

8. Transplants (Determined to be Medically Necessary)
   Heart, Heart/Lung, Lung, Liver, Pancreas, Intestines, Bone Marrow with prior approval required.

9. Kidney Transplants and Dialysis Treatments
   (Prior approval by the Medical Director being required)

10. Alcoholism, Drug Abuse and Nervous or Mental Disorders Services.

11. Prescription Drugs (including Insulin and Transplant Drugs, with prior approval required for certain drugs)
    - Tiered programs may be created - provided that all classes of therapeutically equivalent prescription medications must be available.
    - Birth control agents.