

**NORTH CAROLINA SMALL EMPLOYER GROUP  
STANDARD PREFERRED PROVIDER (PPO) PLAN**

**SUMMARY OF BENEFITS**

	<b>In-Network<sup>1</sup></b>	<b>Deductible</b>	<b>Out-of-Network<sup>2</sup></b>	<b>Deductible</b>
Hospital Services – Inpatient and Outpatient	Plan pays 80%	Applies	Plan pays 50%	Applies
Primary Care Physician Services	Plan pays 80%	Applies	Plan pays 50%	Applies
Specialist Physician Services	Plan pays 80%	Applies	Plan pays 50%	Applies
Wellness & Prevention - from Primary Care Physician <sup>3</sup>	Plan pays 100%	Does not apply	Not covered	Not Covered
Mental Health Inpatient and Outpatient Benefit	Plan pays 80%	Applies	Plan pays 50%	Applies
Mental Health Inpatient/Outpatient Durational Limits <sup>4 5</sup>	30 combined inpatient and outpatient days per year		30 combined inpatient and outpatient days per year	
Mental Health Office Visits	Plan pays 80%	Applies	Plan pays 50%	Applies
Mental Health Office Visit Durational Limits <sup>67</sup>	30 office visits per year		30 office visits per year	
Mental, Nervous & Chemical Dependency - Lifetime Maximum	\$10,000		\$10,000	
Mental, Nervous & Chemical Dependency - Inpatient Benefit	Plan pays 80%	Applies	Plan pays 80%	Applies
Mental, Nervous & Chemical Dependency - Outpatient Benefit	Plan pays 50%	Applies	Plan pays 50%	Applies
1 <sup>st</sup> Prenatal visit during the first three months of pregnancy	Plan pays 100%	Does not apply	Plan pays 100%	Does not apply
Organ Transplant Maximum <sup>8</sup>	\$100,000 per organ		\$100,000 per organ	
Maximum Lifetime Benefit <sup>9</sup>	\$1,000,000		\$1,000,000	
Calendar Year Deductible <sup>10</sup>	\$500		\$1,000	
Calendar Year Deductible per Family	\$1,500		\$3,000	
Out-of-Pocket Maximum <sup>11</sup>	\$2,000		\$4,000	
Out-of-Pocket Maximum per Family	\$4,000		\$8,000	

	<u>In-Network</u>		<u>Out-of-Network</u>	
Plan Pays after out-of-pocket is satisfied	100%		70%	
Emergency Room Deductible per insured per visit <sup>12</sup>	\$50		\$50	
Prescription Drugs <sup>13</sup>	Plan pays 80%	Applies	Plan pays 50%	Applies
All other covered expenses	Plan pays 80%	Applies	Plan pays 50%	Applies

**NOTES**

**A CARRIER WHO HAS A PROVIDER NETWORK AVAILABLE IN THE GEOGRAPHIC LOCATION OF A SMALL EMPLOYER APPLICANT SHALL DISCLOSE THE AVAILABILITY OF THE STANDARD PREFERRED PROVIDER (PPO) HEALTH BENEFIT PLAN TO THE APPLICANT AT THE TIME OF APPLICATION. A CARRIER SHALL ALSO DISCLOSE THE AVAILABILITY OF THE STANDARD HEALTH BENEFIT PLAN TO THE APPLICANT IF THE CARRIER CURRENTLY MARKETS ANY NON-STATUTORY INDEMNITY HEALTH BENEFIT PLANS TO SMALL EMPLOYERS IN THE GEOGRAPHIC REGION OF THE APPLICANT. THE CARRIER SHALL DISCLOSE CONCURRENTLY THE AVAILABILITY OF THE BASIC HEALTH BENEFIT PLAN.**

**EVERY STANDARD HEALTH BENEFIT PLAN THAT IS DELIVERED, ISSUED FOR DELIVERY, OR RENEWED ON OR AFTER JULY 1, 2000 THAT ISSUES A PRESCRIPTION DRUG CARD, SHALL ISSUE TO ITS INSURED A UNIFORM PRESCRIPTION DRUG CARD PURSUANT TO NCGS 58-3-177 AS ADOPTED IN SENATE BILL 513.**

**A CHILD SHALL CEASE TO BE ELIGIBLE FOR COVERAGE AS A DEPENDENT AT AGE 19, OR IF A FULL-TIME STUDENT AT AN ACCREDITED SCHOOL OR COLLEGE, AT AGE 25. THIS DOES NOT APPLY TO A DEPENDENT CHILD WHO IS PHYSICALLY OR MENTALLY HANDICAPPED AND THEREFORE UNABLE TO SUPPORT THEMSELVES AND THE HANDICAP COMMENCED PRIOR TO THE DEPENDENT ATTAINING THE LIMITING AGE**

**DRUGS WHICH HAVE BEEN APPROVED BY THE FEDERAL FOOD AND DRUG ADMINISTRATION (FDA) FOR THE TREATMENT OF CERTAIN TYPES OF CANCER SHALL NOT BE EXCLUDED ON THE BASIS THAT THE DRUG HAD BEEN PRESCRIBED FOR THE TREATMENT OF A CERTAIN TYPE OF CANCER FOR WHICH THE DRUG HAD NOT BEEN APPROVED BY THE FDA**

**VOLUNTARY FAMILY PLANNING IS LIMITED TO TUBAL LIGATIONS AND VASECTOMIES**

**AFTER AN INDIVIDUAL MEETS THE \$100 WELLNESS BENEFIT IN A SINGLE BENEFIT PERIOD, WELLNESS BENEFITS ARE PAYABLE AT 80% SUBJECT TO THE DEDUCTIBLE AND OUT-OF-POCKET LIMIT**

**EVERY STANDARD PPO HEALTH BENEFIT PLAN THAT IS ISSUED, RENEWED, OR AMENDED ON OR AFTER JANUARY 1, 1998 SHALL PROVIDE COVERAGE FOR RECONSTRUCTIVE BREAST SURGERY RESULTING FROM A MASTECTOMY. THIS COVERAGE SHALL BE AT LEAST EQUAL TO THE COVERAGE REQUIRED BY NCGS 58-51-62, INCLUDING THE NOTIFICATION REQUIREMENTS.**

**SUMMARY OF BENEFITS  
(CONTINUED)**

**EVERY STANDARD INDEMNITY HEALTH BENEFIT PLAN THAT IS ISSUED, RENEWED, OR AMENDED ON OR AFTER JULY 1, 1997 SHALL NOT IMPOSE ANY PREEXISTING CONDITION EXCLUSION RELATING TO PREGNANCY AS A PREEXISTING CONDITION**

**EVERY STANDARD INDEMNITY HEALTH BENEFIT PLAN THAT IS IN FORCE, ISSUED, RENEWED OR AMENDED ON OR AFTER JANUARY 1, 2000 SHALL PROVIDE COVERAGE FOR A QUALIFIED INDIVIDUAL FOR SCIENTIFICALLY PROVEN BONE MASS MEASUREMENT FOR THE DIAGNOSIS AND EVALUATION OF OSTEOPOROSIS OR LOW BONE MASS. THIS COVERAGE SHALL BE AT LEAST EQUAL TO THE COVERAGE REQUIRED BY NCGS 58-3-174.**

**EVERY STANDARD INDEMNITY HEALTH BENEFIT PLAN THAT IS IN FORCE, ISSUED, RENEWED, OR AMENDED ON OR AFTER JANUARY 1, 2000 SHALL PROVIDE COVERAGE FOR PRESCRIBED CONTRACEPTIVE DRUGS AND DEVICES THAT PREVENT PREGNANCY. THIS COVERAGE SHALL BE AT LEAST EQUAL TO THE COVERAGE REQUIRED BY NCGS 58-3-176.**

**EVERY STANDARD HEALTH BENEFIT PLAN THAT IS DELIVERED, ISSUED FOR DELIVERY, OR RENEWED ON OR AFTER JANUARY 1, 2002 SHALL PROVIDE COVERAGE FOR COLORECTAL CANCER EXAMINATIONS AND LABORATORY TESTS. THIS COVERAGE SHALL BE AT LEAST EQUAL TO THE COVERAGE REQUIRED BY NCGS 58-3-179.**

**EVERY STANDARD HEALTH BENEFIT PLAN THAT IS DELIVERED, ISSUED FOR DELIVERY, OR RENEWED ON OR AFTER JANUARY 1, 2004 SHALL PROVIDE COVERAGE FOR SURVEILLANCE TESTS FOR OVARIAN CANCER. THIS COVERAGE SHALL BE AT LEAST EQUAL TO THE COVERAGE REQUIRED BY NCGS 58-3-270.**

**EVERY STANDARD HEALTH BENEFIT PLAN THAT IS DELIVERED, ISSUED FOR DELIVERY, OR RENEWED ON OR AFTER JULY 1, 2008 SHALL PROVIDE COVERAGE FOR TREATMENT OF MENTAL ILLNESS THAT IS AT LEAST EQUAL TO THE COVERAGE REQUIRED BY NCGS 58-3-220.**

## COVERED EXPENSES

Covered Expenses are those which can apply to meet the deductible amount or for which benefits can be paid. Covered expenses include the following charges for services or supplies ordered by a doctor for the medical care of injury or sickness. **In general, in-network benefits are paid at 80% and out-of-network are paid at 50%. Both types are subject to the deductible unless the benefit summary indicates otherwise. Note that some limitations may apply.**

1. Charges made by hospitals for:
  - a) Room and board and any nurse care for each day of hospital confinement, but not more than the charges of the hospital for a two-bed room of its largest class of two-bed rooms;
  - b) Confinement in an intensive care unit of the hospital for each day of confinement in an intensive care unit, but not more than 300% of the charges of the hospital for a two-bed room of its largest class of two-bed rooms; and
  - c) Other hospital services and supplies; and
2. If not included in 1. above, charges made by :
  - a) Doctors, other than a doctor who normally lives in your home or who is a member of your immediate family, for medical or surgical care, including an assistant surgeon.
  - b) Registered Nurses, other than a nurse who normally lives in your home or who is a member of your immediate family, for Private Duty Nursing Care.
  - c) Physical Therapist, other than physical therapist who normally lives in your home or who is a member of your immediate family, for Outpatient Physical Therapy.
  - d) Doctors or professional anesthetists for furnishing and giving anesthetics.
  - e) Radiologists or Laboratories for diagnosis or treatment.
  - f) Professional ambulance service for taking the patient to or from a hospital.
  - g) Others for:
    - i) Drugs or medicines that are ordered for the patient in writing by a doctor and dispensed by a licensed pharmacist or a doctor;

- ii) Blood or other fluids to be injected into the circulatory system.

**COVERED EXPENSES  
(CONTINUED)**

- iii) Casts or Splints
- iv) Surgical dressings
- v) The first supply of the following prosthetic appliances and medical supplies, artificial limbs or eyes, trusses, braces or crutches; however replacement is not covered.
- vi) The first supply of an external breast prosthetic device that is prescribed after a mastectomy performed while the patient is insured; however, the replacement of such item is not covered.
- vii) Oxygen and the purchase or rental, whichever is least expensive as determined by the insuring entity, of equipment to give it.
- viii) The purchase or rental, whichever is lease expensive as determined by the insuring entity, of a wheel chair, a hospital type bed, or mechanical equipment to treat respiratory paralysis.
- h) Extended Care Facility for charges for room and board and skilled nursing care limited to a rate of one-half of the semi-private rate of the hospital where confined prior. No more than 100 days of confinement in twelve consecutive months will be covered. Confinement must commence within 14 days of a hospital stay of at least 3 days which was payable under the plan and the term of care in the extended care facility is continuous. A doctor must certify the care is required due to a need for skilled nurse care. The care of the patient must be supervised by a doctor at all times. This does not include confinements that are custodial.
- i) Maternity Care for insured employee/subscriber/member and the insured dependent spouse only (except complications of pregnancy are covered for all insureds). Includes inpatient care for a mother and her newly born child for a minimum of forty-eight (48) hours after vaginal delivery and a minimum of ninety-six (96) hours after delivery by cesarean section. Coverage shall include timely post-delivery care, if the physician, in consultation with the mother, discharges the mother and the newborn prior to the expiration of the minimum stays.
- j) Treatment of Mental and Nervous Disorders and chemical dependency. **Mental health benefits shall be provided in compliance with NCGS 58-3-220.**

**COVERED EXPENSES  
(CONTINUED)**

- k) Organ Transplant limited to human-to-human, non-experimental organ transplants. Includes charges for:
  - i) initial testing and diagnosis;
  - ii) immunosuppressant drug therapy before and subsequent to the surgery, no matter how long after the surgery;
  - iii) complications resulting from surgery, organ rejection or failure, whether current or anticipated; and
  - iv) any repeat transplants of the same type of organ.
  
- l) Wellness Benefits including Pap Smears, Mammograms, Prostate-Specific Antigen Test and other specified wellness benefits subject to limits as specified.
  
- m) Outpatient Chiropractic Care
  
- n) Hospice Care
  
- o) Voluntary Family Planning
  
- p) Scientifically proven bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass for qualified individuals. Coverage must be at least equal to the coverage required by NCGS 58-3-174.
  
- q) Reconstructive breast surgery resulting from a mastectomy due to breast cancer or breast disease. The coverage shall include coverage for all stages and revisions of reconstructive breast surgery performed on a nondiseased breast to establish symmetry when reconstructive surgery on a diseased breast is performed. Subject to the approval of the treating physician, reconstruction of the nipple/areolar complex following a mastectomy is covered without regard to the lapse of time between the mastectomy and the reconstruction. Coverage must be at least equal to the requirements of NCGS 58-51-62, including the notification requirements.
  
- r) Prescribed contraceptive drugs and devices to prevent pregnancy. Coverage must be at least equal to the coverage required by NCGS 58-3-176.
  
- s) Colorectal cancer examinations and laboratory tests. Coverage must be at least equal to the coverage required by NCGS 58-3-179.
  
- t) Surveillance tests for women age 25 and older as risk for ovarian cancer. Coverage must be at least equal to the coverage required by NCGS 58-3-270.

**SCHEDULE OF BENEFITS**

<b>SERVICES</b>	<b>IN-NETWORK BENEFITS</b>	<b>OUT-OF-NETWORK BENEFITS</b>
BENEFIT PERIOD	CALENDAR YEAR	CALENDAR YEAR
BENEFIT PAYABLE	80%	50%
INDIVIDUAL DEDUCTIBLE	\$500	\$1,000
FAMILY DEDUCTIBLE	3 x individual	3 x individual
INDIVIDUAL OUT-OF-POCKET LIMIT	\$2,000	\$4,000
FAMILY OUT-OF-POCKET LIMIT	2 x individual	2 x individual
BENEFIT PAYABLE AFTER OUT-OF-POCKET LIMIT IS MET	100%	70%

THE FOLLOWING APPLY TO BOTH IN-NETWORK AND OUT-OF-NETWORK BENEFITS

The Out-of-Pocket Limit will not include any amount applied to the Deductible

The Out-of-Pocket Limit will not include any expense disallowed for services which are received contrary to any provisions of the policy

Outpatient **Mental & Nervous Disorder Services**, Chemical Dependency Treatment, Outpatient Chiropractic Services, and Physical Therapy Services will not apply to the Out-of-Pocket Limit

MAXIMUMS:  
for

\$1,000,000 per Lifetime per Insured

all Covered Services, including Covered Services with specific maximum benefits; and specifically Mental Health benefits.

\$10,000 per Lifetime per Insured for **Mental & Nervous Disorder** and Chemical Dependency Benefits

**SCHEDULE OF BENEFITS  
(CONTINUED)**

\$10,000 per Lifetime per Insured for  
Outpatient Private Duty Nursing (Limited to  
\$2,500 per Benefit Period)

\$100,000 per Lifetime per Insured per  
Organ for Organ Transplants

The following benefits are paid at 80% of Provider's Reasonable Charge for in-network and at 50% of Provider's Reasonable Charge for out-of-network unless noted otherwise. See Covered Expenses Section and Summary of Plan of further clarifications.

❖ **HOSPITAL SERVICES:**

- Inpatient and Outpatient Services
- Emergency Care – initial visit/inpatient stays are payable at the in-network level if the condition meets the definition of emergency care

❖ **SURGICAL SERVICES:**

- Surgeon and Assistant Surgeon
- Anesthesia

❖ **MEDICAL CARE:**

- Inpatient Medical Care Services
- Outpatient Medical Care Service including:
  - Outpatient Prescription Drugs
  - Outpatient Diagnostic Services
  - Outpatient Physical Therapy: \$40 maximum charge per visit  
20 Physical Therapy visits per Benefit  
Period per Insured.
  - Outpatient Physical Therapy Benefit: 50% both in-network and out-of-network

**SCHEDULE OF BENEFITS  
(CONTINUED)**

- Maternity Care Services: As any other illness, for insured employee/ subscriber/member & the insured dependent spouse only, including inpatient care for a mother and her newly-born child for a minimum of forty-eight (48) hours after vaginal delivery and a minimum of ninety-six (96) hours after delivery by cesarean section, and timely post-delivery care for the mother and the newly born child if the physician, in consultation with the mother, discharges the mother and the newly born child prior to the expiration of the minimum stays; doctor's charges for first prenatal visit are paid at 100% (both in-network and out-of-network) if the visit is within three months after the pregnancy begins
  
- Mental Health Benefit 80% / 50%  
(in-network/out-of-network)
  - Combined Inpatient and Outpatient Visits Limits<sup>14</sup> 30 days per year
  - Office Visits Limits<sup>15</sup> 30 visits per year
  
- ~~Mental & Nervous Disorder~~ Chemical Dependency Treatment (both in-network and out-of-network)
  - Outpatient Limits: \$60 maximum charge per visit  
25 Outpatient visits per Benefit Period per Insured
  - Outpatient ~~Mental & Nervous Disorder~~ and Chemical Dependency Treatment Benefit: 50%
  - Inpatient ~~Mental & Nervous Disorder~~ and Chemical Dependency Treatment Benefit: 80%
  
- Chiropractic Care Services (both in-network and out-of-network)

- Outpatient Limits: \$40 maximum charge per visit  
35 Outpatient visits per Benefit Period per Insured
  - Outpatient Chiropractic Benefit: 50%
- Organ Transplant Services: \$100,000 per Organ per Lifetime per Insured  
includes bone marrow transplant; limited to human-to-human, non-experimental organ transplants; carriers can cover other types, i.e., artificial-to-human, animal-to-human, experimental with the permission of the Commissioner
- Hospice Care  
A coordinated program for meeting the special: (a) physical; (b) psychological; (c) spiritual; and (d) social needs of dying individuals and their families. Providing palliative and supportive medical, nursing and other health services through home or inpatient care during the illness to persons who have no reasonable prospect of cure and, as estimated by a doctor, have a life expectancy of 6 months or less; and the families of those persons
- Ambulance Service
- Medical Supplies and Prosthetic Appliances
- Voluntary Family Planning

**SCHEDULE OF BENEFITS  
(CONTINUED)**

**ALL WELLNESS/PREVENTION BENEFITS ARE LIMITED TO IN-NETWORK ONLY**

- Wellness Benefits: First \$100 per benefit period per insured is not subject to the deductible; then subject to deductible and coinsurance
  
- Well Child Care and Immunization: 100% of UCR; if individual has used the \$100 Wellness Benefit during a benefit period, then immunizations administered to that individual during the remainder of that benefit period shall be paid at 80% subject to deductible and out-of-pocket limit
  
- Routine Physical Examinations: 100% of UCR
  - Benefits are limited to: General health checkups, x-rays, blood pressure checks, urine tests, tuberculosis tests, routine diagnostic tests, colon exams, prostate exams and rectal exams
  
  - Benefits for routine diagnostic procedures are limited to:
    - ◆ once every 3 years for Insureds from 19 to 39 years of age
    - ◆ once every 2 years for Insureds from 40 to 55 years of age
    - ◆ once every year for Insureds 56 years of age and older.
  
- Pap Smears : Limit of 1 per Benefit period per Insured, unless recommended more often by a Provider.
  
- Mammography:
  - One or more mammograms per year, for female insureds, as recommended by a provider for any woman at risk of breast cancer
  - A single mammogram for any woman age 35 through 39
  - A mammogram every other year for any woman age 40 through 49
  - A mammogram every year for any woman age 50 or older
  - Or more frequently as a Provider recommends
  
- PSA Tests As recommended by a physician

## EXCLUSIONS

Benefits will not be paid for charges:

1. For, or in connection with, the care or treatment of an injury or sickness due to war or an act of war, declared or undeclared;
2. For medical services or supplies if no charge would have been made if the patient did not have this insurance;
3. For the care or treatment of an injury that is intentionally self-inflicted, while sane or insane unless otherwise required to be covered by Federal law;

Federal law requires that if a group plan generally provides benefits for a type of injury, the plan may not deny benefits otherwise provided for the treatment of the injury because of the manner by which the injury is incurred if the injury is attributed to an underlying medical condition (including both physical and mental health conditions) or the injury is attributed to an act of domestic violence.

4. For the care or treatment of an injury due to the commission of, or an attempt to commit, an assault or a felony or an injury or sickness incurred while engaging in an illegal act or occupation;
5. For the care or treatment of an injury or sickness due to voluntary participation in a riot;
6. For custodial or sanitarium care or rest cures;
7. For treatment in a facility, or part of a facility, that is mainly a place for: (a) rest; (b) convalescence; (c) custodial care; (d) the aged; (e) the care or treatment of alcoholism or drug addiction; (f) rehabilitation; or (g) training, schooling or occupational therapy;
8. For treatment with new drugs or technological medical devices which are experimental in nature;
9. For testing eyesight or purchase or fitting to glasses, contact lenses (except following cataract surgery), hearing aids, corrective shoes, or other corrective devices or appliances;
10. For exams or tests for check-up purposes that are not for the treatment of injury or sickness; except as otherwise noted.
11. For treatment or surgery for obesity, weight reduction or weight control;
12. For orthomolecular therapy including nutrients, vitamins and food supplements;

**EXCLUSIONS  
(CONTINUED)**

13. For radial keratotomy, myopic keratomileusis and any surgery which involves corneal tissue for the purpose of altering, modifying or correcting myopia, hyperopia or stigmatic error;
14. For dental work or treatment which includes hospital or professional care in connection with: an operation or treatment for the fitting or wearing of dentures; orthodontic care or treatment of malocclusion; and operations on or treatment of or to the teeth or supporting tissues of the teeth except for: removal of malignant tumors and cysts; or treatment of an injury to natural teeth due to an accident (other than an accident occurring while, and as a result of eating or chewing), if the accident occurs while the patient is insured and the treatment is received within twelve months after the accident;
15. For treatment of weak, strained or flat feet, including orthopedic shoes or other supportive devices, or for cutting, removal or treatment of corns, calluses or nails, other than with corrective surgery, or for metabolic or peripheral vascular disease;
16. For lifestyle improvements, including smoking cessation, nutrition counseling or physical fitness programs;
17. For speech therapy, except to restore speech abilities which were lost due to injury or sickness;
18. For the correction of, or complications arising from, treatment or an operation to improve appearance if the original treatment or operation either was not a Covered Expense under the Group Policy or would not have been a Covered Expense if the patient had been insured; except as required for reconstructive breast surgery in accordance with NCGS 58-50-155(a2) and NCGS 58-51-61.
19. In connection with the care of a pre-existing condition, except in the case of a late-enrollee, for not more than 12 months; however, the plan shall provide credit for creditable coverage in accordance with NCGS 58-68-30(a)(3). This exclusion will not apply to a pregnancy, which shall never be considered a preexisting condition.
20. Due to the pregnancy of a dependent child. This exclusion will not apply to medical care due to complications of pregnancy;
21. Services or supplies for the treatment of an Occupational Injury or Sickness which are paid under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act;

**EXCLUSIONS  
(CONTINUED)**

22. For pre-conception testing or genetic testing; for artificial insemination or an implant procedure to induce pregnancy; for in vitro fertilization; for a procedure to reverse a surgically performed sterilization; or for a sex change;
23. For treatment that is not medically necessary for the care of an injury or sickness except as specifically noted in the Wellness Benefit;
24. To the extent that they are more than either: (a) the customary charge made by the provider for the treatment furnished; or (b) the general level of charges made by others in the same locality for such treatment. If the amount of the customary charges or the general level of charges for a service cannot be determined due to the unusual nature of the service, XYZ will determine the amount XYZ will take into account: (a) the complexity involved; (b) the degree of professional skill required; and (c) other pertinent factors;
25. For surgery and any related services intended to solely improve appearance, but not to restore bodily function or correct deformity resulting from disease, trauma, congenital or developmental anomalies;
26. Rendered by a Provider who is a member of the Insured's immediate family;
27. For organ transplants which are considered experimental, related to transplantation of animal organ or tissues, or related to transplantation of artificial organs or tissues;
28. For weekend admission charges, except for emergencies and maternity care;
29. For telephone consultations, charges for failure to keep a scheduled visit, charges for completion of any form or charges for medical information;
30. For the treatment of Temporomandibular Joint Dysfunction (TMJ) or Craniomandibular Pain Syndrome (CPS), except surgical services for TMJ and CPS are covered, but only if medically necessary and there is clearly demonstrable radiographic evidence of joint abnormality due to disease or injury;

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<sup>1</sup> When no network provider exists for a payable benefit, the benefit shall be paid at the in-network level and is subject to the in-network deductible, out-of-pocket limit and coinsurance.

<sup>2</sup> Benefits payable under out-of-network plan apply toward the in-network deductibles and out-of-pocket limits; but **except for mental health benefits**, benefits payable in-network do not apply to out-of-network deductibles and out-of-pocket limits.

<sup>3</sup> Wellness benefit limit of \$100 per calendar year per individual not subject to the deductible.

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<sup>4</sup> Except when services are provided for Bipolar Disorder, Major Depressive Disorder, Obsessive Compulsive Disorder, Paranoid and Other Psychotic Disorder, Schizoaffective Disorder, Schizophrenia, Post-Traumatic Stress Disorder, Anorexia Nervosa, and Bulimia, which shall not be subject to any durational limitations.

<sup>5</sup> Total of 30 combined inpatient/outpatient days per year and includes both in-network and out-of-network provider visits.

<sup>6</sup> Except when services are provided for Bipolar Disorder, Major Depressive Disorder, Obsessive Compulsive Disorder, Paranoid and Other Psychotic Disorder, Schizoaffective Disorder, Schizophrenia, Post-Traumatic Stress Disorder, Anorexia Nervosa, and Bulimia, which shall not be subject to any durational limitations.

<sup>7</sup> Total of 30 office visits per year and includes both in-network and out-of-network provider visits.

<sup>8</sup> Limited to human-to-human; non-experimental organ transplants. Carriers can cover other types, i.e. Artificial-to-human, animal-to-human, experimental, with the permission of the commissioner.

<sup>9</sup> Includes Mental Health benefits.

<sup>10</sup> Per individual per calendar year.

<sup>11</sup> Per individual per calendar year.

<sup>12</sup> Waived if admitted; initial true emergency care shall be payable as an in-network benefit, even when not rendered by a participating provider, subject to in-network deductibles, out-of-pocket limits and coinsurance. The policy/certificate must contain a definition of "emergency care".

<sup>13</sup> Prescription drug benefit does include oral contraceptives regardless of prescribed use

<sup>14</sup> Except when services are provided for Bipolar Disorder, Major Depressive Disorder, Obsessive Compulsive Disorder, Paranoid and Other Psychotic Disorder, Schizoaffective Disorder, Schizophrenia, Post-Traumatic Stress Disorder, Anorexia Nervosa, and Bulimia, which shall not be subject to any durational limitations.

<sup>15</sup> Except when services are provided for Bipolar Disorder, Major Depressive Disorder, Obsessive Compulsive Disorder, Paranoid and Other Psychotic Disorder, Schizoaffective Disorder, Schizophrenia, Post-Traumatic Stress Disorder, Anorexia Nervosa, and Bulimia, which shall not be subject to any durational limitations.