STATE OF TENNESSEE
DEPARTMENT OF COMMERCE AND INSURANCE
LEGAL SERVICES
500 JAMES ROBERTSON PARKWAY
VOLUNTEER PLAZA BUILDING, FIFTH FLOOR
NASHVILLE, TENNESSEE 37243

NED McWHERTER
GOVERNOR

ELAINE A. McREYNOLDS
COMMISSIONER

B U L L E T I N

TO: All Tennessee Small Employer Carriers

FROM: Elaine A. McReynolds
Commissioner

RE: Basic and Standard Health Care Plans

DATE: July 8, 1993

Enclosed is a copy of the July 1, 1993 Order approving the basic and standard health care plans for insurance and for HMOs. Also enclosed are the plans including modifications specified in the Order. Pursuant to Tennessee Code Annotated Section 56-7-2208 every small employer carrier shall offer at least one (1) basic and one (1) standard health care plan by January 1, 1994.

Based on both oral and written comments received by the Department some clarification is necessary. Neither the basic nor the standard benefit plans (non-HMO) list benefits for in-hospital items such as physician charges, in-patient miscellaneous hospital charges and prescription drugs. However, these plans are basically major medical plans with certain specified limitations and exceptions. It is not possible to list all the covered in-hospital charges in a major medical policy. It is intended that these plans pay the ordinary in-hospital charges up to the coverage limits.

The Department is concerned that there not be abuses in the area of the usual and customary charges and we will require that all small employer carriers file, along with their rates, the bases used for determining their usual and customary charges. In addition, the Department will also be requiring that carriers file the bases used for their setting of standards for experimental treatments. The goal of these additional filings is the standardization of procedures used by the Department in the evaluation of complaints under the Unfair Trade Practices Act.

Further bulletins or notices may be issued from time to time if the need arises to clarify other aspects of the plans. Please direct questions regarding the plans to the Actuarial Section.

EAM:JL:MC
Enclosures

STATE OF TENNESSEE
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NED McWHERTER
GOVERNOR

ELAINE A. McREYNOLDS
COMMISSIONER

IN THE MATTER OF:

TENNESSEE SMALL EMPLOYER GROUP HEALTH COVERAGE REFORM ACT CONSIDERATION OF BASIC AND STANDARD HEALTH CARE PLANS

Docket No.: 93-19

ORDER

Pursuant to Tennessee Code Annotated Section 56-7-2208(b) a public hearing was held by the Commissioner of the Department of Commerce and Insurance to consider whether to either approve, modify or disapprove the basic and standard health care plans submitted and recommended by the Tennessee Small Employer Carrier Committee in accordance with Tennessee Code Annotated Section 56-7-2208(a). Under consideration at the hearing were the following:

1. The proposed basic health care plan as contained in the report of the basic plan sub-committee;

2. The proposed standard health care plan as contained in the report of the standard plan sub-committee;

3. The proposed HMO plans as contained in the report of the HMO sub-committee.

Based on a careful review of the plans submitted and the comments presented both at the hearing and following the hearing it is decided that the plans should be approved with the following modifications:

1. In both the basic and standard insurance plans number 8 of the listed exclusions shall read, "for experimental treatment, including treatment with new drugs or technological medical devices which are experimental in nature;"

2. In the standard insurance plan number 19 of the listed exclusions shall read, "for inpatient private duty nursing care;"

3. In both the basic and standard insurance plans number 21 of the listed exclusions shall read, "in connection with the care of a pre-existing condition as defined in the contract;"

It is therefore **ORDERED** that the health care plans submitted pursuant to Tennessee Code Annotated Section 56-7-2208(a) are **APPROVED** as modified herein.

This 1st day of July, 1993.

Elaine A. McReynolds

Elaine A. McReynolds, Commissioner
Department of Commerce & Insurance
State of Tennessee

TENNESSEE: PLAN SUMMARIES

Benefits	Basic Plan	Standard Plan
Overall Maximum	Annual: $100,000 per Insured	Lifetime: $1,000,000 per Insured
Benefit Percentage • Non-PPO • PPO Note: Non-PPO Plan Must Be Offered Even If Insurer Offers PPO Plan in the Area.	• 60% • In-Network: Not Greater than 60% Out-of-Network: Not Greater than 50% Nor Less than 40%	• 80% • In-Network: Not Greater than 80% Out-of-Network: Not Greater than 70% Nor Less than 50%
Deductible • Benefit Period • Comprehensive Limit • Emergency Room • Carryover Credit • Family Limit • Waiver	• Calendar Year • $300 per Insured • $50 per Visit, Waived When Admitted • Not Covered • 3 Deductibles per Family • No Deductible and 100% Payment on First Prenatal Visit if Within 3 Months after Conception	• Same as Basic Plan • $500 per Insured • Same as Basic Plan • Same as Basic Plan • Same as Basic Plan • Same as Basic Plan
Out-of-Pocket Limits • Insured • Family	• $6,000 per Year (Plus $300 Deductible) • $12,000 per Year (Plus Deductibles to $900) • PPO: Out-of-Network at Discretion of Insurer, Subject to Department of Insurance's Approval.	• $2,500 per Year (Plus $500 Deductible) • $5,000 per Year (Plus Deductibles to $1,500) • PPO: Same as Basic Plan

Preventive Care • Annual Maximum Limit • Well Baby Care and Immunizations • Routine Physical Examination - Routine Diagnostic Procedures - Pap Smears - Mammography	 • $100 per Insured • 100% of Provider's Reasonable Charge • 100% of Provider's Reasonable Charge; Limited to General Health Checkups, X-Rays, Blood Pressure Checks, Urine Tests, Tuberculosis Tests, Routine Diagnostic Tests, Colon Exams, Prostate Exams, and Rectal Exams - Age 0-39: Once Every Three Years Age 40-54: Once Every Two Years Age 55+: Once/Year - One per Insured per Year - Limited to Female Insureds: Age 35-39: Once Age 40-49: Once/Year or As Recommended by Doctor Age 50+: Once/Year	Not Covered
Hospital Room and Board	Average Semi-Private Rate	Same as Basic Plan
Intensive Care Unit	Reasonable & Customary	Same as Basic Plan
Extended Care Facility • Payment Rate • Maximum Limit	 • 50% of Average Semi-Private Rate at Hospital of Prior Confinement • 100 Days	 • Same as Basic Plan • Same as Basic Plan
Maternity	Less than 10 Employees: $1,500 10 or More Employees: As Any Other Illness	Same as Basic Plan

Mental/Nervous/Alcoholism/Drug Abuse • Lifetime Maximum • Inpatient • Outpatient - Maximum Charge/Visit - Number of Visits/Year	Not Covered	 • $10,000 per Insured • Paid at 50%, Subject only to Lifetime Maximum on Mental/Nervous • Covered - 50% with a Maximum Covered Charge of $60 ($30 Maximum Benefit) - 30
Private Duty Nursing • Inpatient • Outpatient - Calendar Year Limit - Lifetime Maximum	Not Covered	 • Not Covered • Covered - $2,500 per Insured - $10,000 per Insured
Organ Transplant • Lifetime Maximum for Same Type of Organ • Covered Charges	• $50,000 • Initial Testing & Diagnosis • Immunosuppressant Drug Therapy before & after Surgery • Complications Resulting from Surgery, Organ Rejection/Failure • Any Repeat Transplants of Same Type of Organ	• $100,000 • Same as Basic Plan
Outpatient Physical Therapy • Maximum Charge/Visit • # of Treatments/Year	Not Covered	 • 50% with a Maximum Covered Charge of $40 ($20 Maximum Benefit) • 20
Skeletal Adjustment/ Adjunctive Therapy/ Vertebral Manipulation/ Dislocation-Subluxation Services	Not Covered	Limited???

LIMITATIONS

Benefits for expenses for care or treatment related to an organ transplant are limited. The benefits are limited to the extent shown in the Schedule of Insurance. The limit applies to all Covered Expenses relating to the organ being transplanted including charges for:

1. initial testing and diagnosis;
2. immunosuppressant drug therapy before and subsequent to the surgery, no matter how long after the surgery;
3. complications resulting from the surgery, organ rejection or failure, whether current or anticipated; and
4. any repeat transplants of the same type of organ.

(The following limitation applies to employers with less than 10 employees).

Benefits for expenses for care or treatment related to a pregnancy, other than expenses for complications of pregnancy, are limited. The benefits are limited to the extent shown in the Schedule of Insurance.

Services or supplies obtained through the laws or regulations of a government will be deemed Covered Expenses only to the extent that a charge is made that the patient is legally required to pay. Government includes the government of a state, commonwealth, territory, province or a political division of them. It also includes an agency of a state or local government.

Only certain charges for, or related to, treatment or operations to improve appearance will be Covered Expenses. They will be deemed to be Covered Expenses only if they are for:

1. repair of disfigurement due to an accident which occurs while the patient is insured and the treatment begins within ninety days after the accident; or
2. correction of a birth defect.

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;

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) convalescense; (c) custodial care; (d) the aged; (e) rehabilitation; or (f) training, schooling or occupational therapy;
8. for experimental treatment, including treatment with new drugs or technological medical devices which are experimental in nature;
9. for testing eyesight or purchase or fitting of 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 provided for in the Schedule of Benefits;
11. for dental work or treatment which includes hospital or professional care in connection with:
    (a) an operation or treatment for the fitting or wearing of dentures;
    (b) orthodontic care or treatment of malocclusion; and
    (c) operations on or treatment of or to the teeth or supporting tissues of the teeth except for:
        (1) removal of malignant tumors and cysts; or
        (2) 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;
12. for treatment or surgery for obesity, weight reduction or weight control;
13. for orthomolecular therapy including nutrients, vitamins and food supplements;
14. for radial keratotomy, myoptic keratomileusis and any surgery which involves corneal tissue for the purpose of altering, modifying or correcting myopia, hyperopia or stigmatic error;
15. for treatment of weak, strained or flat feet, including orthopedic shoes or other supportive devices, or for cutting, removal or treatment of corns, callouses or nails, other than with corrective surgery, or for metabolic or peripheral vascular disease;
16. for lifestyle improvements, including smoking cessation, nutrition counselling or physical fitness programs;
17. for speech therapy, except to restore speech abilities which were lost due to injury or sickness;

18. for, or in connection with, home health care;
19. for inpatient or outpatient private duty nursing care;
20. 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;
21. in connection with the care of a pre-existing condition as defined in the contract;
22. due to a sickness for which the patient can receive benefits under a workers' compensation act or similar law;
23. due to an injury that arises out of or in the course of a job or employment for pay or profit;
24. 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;
25. for treatment that is not medically necessary for the care of an injury or sickness except as provided in the Schedule of Benefits; or
26. 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;
27. for inpatient and outpatient psychiatric care, alcoholism and drug addiction;
28. for physical therapy if treatment is received while the patient is not confined to a hospital as a bed patient;
29. for skeletal adjustments, adjunctive therapy, vertebral manipulation and services for the care or treatment of dislocations or subluxations of a vertebrae;
30. for treatment for Temporomandibular Joint Dysfunction (TMJ) and Crainiomandibular 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 illness or injury.

TENNESSEE STANDARD PLAN

LIMITATIONS

Benefits payable for the charges for the care of mental or nervous conditions and alcoholism and drug addiction are limited. They are limited to the extent shown in the Schedule of Insurance.

Charges for physical therapy that are Covered Expenses may be limited. They will be limited if they are made for treatment received while the patient is not confined to a hospital as a bed patient. The charges will be deemed Covered Expenses only to the limited extent shown in the Schedule of Insurance.

Charges of a doctor for skeletal adjustment, adjunctive therapy, vertebral manipulation and services for the care or treatment of dislocations of subluxations of the vertebrae that are Covered Expenses may be limited. They will be limited if they are made for treatment received while the patient is not confined to a hospital as a bed patient. The charges will be deemed Covered Expenses only to the limited extent shown in the Schedule of Insurance.

Benefits for expenses for care or treatment related to an organ transplant are limited. The benefits are limited to the extent shown in the Schedule of Insurance. The limit applies to all Covered Expenses relating to the organ being transplanted including charges for:

1. initial testing and diagnosis;
2. immunosuppressant drug therapy before and subsequent to the surgery, no matter how long after the surgery;
3. complications resulting from the surgery, organ rejection or failure, whether current or anticipated; and
4. any repeat transplants of the same type of organ.

(The following limitation applies to employers with less than 10 employees.)

Benefits for expenses for care or treatment related to a pregnancy, other than expenses for complications of pregnancy, are limited. The benefits are limited to the extent shown in the Schedule of Insurance.

Services or supplies obtained through the laws or regulations of a government will be deemed Covered Expenses only to the extent that a charge is made that the patient is legally required to pay. Government includes the government of a state, commonwealth, territory, province or a political division of them. It also includes an agency of a state or local government.

Only certain charges for, or related to, treatment or operations to improve appearance will be Covered Expenses. They will be deemed to be Covered Expenses only if they are for:

1. repair of disfigurement due to an accident which occurs while the patient is insured and the treatment begins within ninety days after the accident; or
2. correction of a birth defect.

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;
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) rehabilitation; or (f) training, schooling or occupational therapy;
8. for experimental treatment, including treatment with new drugs or technological medical devices which are experimental in nature;
9. for testing eyesight or purchase or fitting of 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;
11. for dental work or treatment which includes hospital or professional care in connection with:
    (a) an operation or treatment for the fitting or wearing of dentures;
    (b) orthodontic care or treatment of malocclusion; and
    (c) operations on or treatment of or to the teeth or supporting tissues of the teeth except for:
        (1) removal of malignant tumors and cysts; or
        (2) 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;

12. for treatment or surgery for obesity, weight reduction or weight control;
13. for orthomolecular therapy including nutrients, vitamins and food supplements;
14. for radial keratotomy, myoptic keratomileusis and any surgery which involves corneal tissue for the purpose of altering, modifying or correcting myopia, hyperopia or stigmatic error;
15. for treatment of weak, strained or flat feet, including orthopedic shoes or other supportive devices, or for cutting, removal or treatment of corns, callouses or nails, other than with corrective surgery, or for metabolic or peripheral vascular disease;
16. for lifestyle improvements, including smoking cessation, nutrition counselling or physical fitness programs;
17. for speech therapy, except to restore speech abilities which were lost due to an injury or sickness;
18. for, or in connection with, home health care;
19. for inpatient private duty nursing care;
20. for the correction of, or complications arising from, treatement 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;
21. in connection with the care of a pre-existing condition as defined in the contract;
22. due to a sickness for which the patient can receive benefits under a workers' compensation act or similar law;
23. due to an injury that arises out of or in the course of a job or employment for pay or profit;
24. 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;
25. for treatment that is not medically necessary for the care of an injury or sickness; or
26. 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 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.

27. for treatment for Temporomandibular Joint Dysfunction (TMJ) and Crainiomandibular Pain Syndrome (CPS), except surgical services for TMJ and CPS are covered, buy only if medically necessary and there is clearly demonstrable radiographic evidence of joint abnormality due to illness or injury.

HMO

BASIC SCOPE OF BENEFITS

ALL CARE MUST BE RENDERED OR REFERRED BY THE PRIMARY CARE PHYSICIAN FOR THE CHARGES TO BE PAID BY THIS HEALTH CARE PLAN.

BENEFITS (subject to conditions & exclusions listed elsewhere)	**PLAN PAYS**
INPATIENT HOSPITAL SERVICES	
$500 deductible per admission not to exceed 50% of charges	
Room and Board	*80% Semi-Private
Length of Stay	Unlimited
Charges other than room and board	*80%
INPATIENT HOSPITAL PHYSICIAN SERVICES	
Any services rendered by the Primary Care Physician or by a Consultant when referred by the Primary Care Physician	100%
OUTPATIENT SURGERY PHYSICIAN SERVICES	100%
EMERGENCY ROOM SERVICES	*80% after $50.00 Copay
INPATIENT PRIVATE DUTY NURSING	
When medically necessary and authorized by this Plan's Medical Director	*80%
OUTPATIENT HOSPITAL SERVICES	*80%
Including Ambulatory Surgical Centers	
MEDICAL OFFICE VISITS	100% after $15.00 Copay
PREVENTIVE HEALTH SERVICES	
Well-baby care, routine exams, family planning, routine gynecological exams, vision and hearing screening through age 17	100% after $15.00 Copay
IMMUNIZATIONS	100%
ALLERGY TESTING	100% after $15.00 Copay
Allergy injections and allergens	100%
MATERNITY CARE	
Hospital Services	*Paid as any other condition
Physician Services	100% after $15.00 Copay
HOME HEALTH CARE	
Services are covered when medically necessary	100% after $15.00 Copay
OUTPATIENT MENTAL HEALTH SERVICES	
Up to 20 visits per calendar year	100% after $50.00 Copay
REHABILITATION SERVICES	
Short-term therapy when prescribed by the Primary Care Physician	*80%
SERVICES FOR ALCOHOL and DRUG ABUSE	
Acute Detoxification Stage Only	*80%
SKILLED NURSING FACILITY	
$500 deductible per admission not to exceed 50% of charges	
Up to 60 days per calendar year	*80%
AMBULANCE SERVICES	
Ground service for emergency	*80% after $50.00 Copay

BASIC SCOPE OF BENEFITS

X-Ray and Laboratory Test.....*80%
Including pap test and mammograms
Hospice Care.....*80%
Physical, Occupational & Speech Therapy..... $10 per visit up to 2 months
When necessary and authorized by this Plan's Medical Director

*For these services the employee pays 20% of the first $25,000 ($5,000) per member per calendar year. For the remainder of that year, benefits are paid at 100%. In addition, hospital and skilled nursing facility admissions are subject to a $500 deductible per admission.

WHAT IS NOT COVERED

A. Services of non-participating providers, except in an emergency or for out-of-area benefits, or when authorized in advance in writing by this plan.
B. Services and treatment of mental retardation and other mental health services, except as otherwise provided in Part V (J).
C. Eyeglasses, contact lenses, hearing aids and other vision care services, except medical services required for diagnosis and treatment of diseases of, or injury to, the eyes or ears, and Preventive Health Services for children through age 17.
D. Cosmetic or reconstructive surgery, unless deemed medically necessary by a participating physician with the prior approval of this plan to restore normal physiological functioning, or to correct a congenital condition.
E. Outpatient private duty nursing.
F. Non-prescription drugs, medications and contraceptive devices, including birth control pills.
G. Personal comfort items (such as radio, television, telephone and guest meals); private rooms, unless necessary during inpatient hospitalization.
H. Custodial or domiciliary care, or convalescent care not requiring skilled nursing in the opinion of the participating physician.
I. All dental services, except oral surgery.
J. Ambulance service, unless medically necessary.
K. Long-term physical therapy and rehabilitation services.
L. Medical, surgical, or other health care procedures deemed to be experimental by the Department of Health and Human Services.
M. Reversals of voluntarily induced infertility and in vitro fertilization procedures.
N. Elective abortions.
O. Procedures, services, and supplies related to sex transformations.
P. Care for military service-connected disabilities for which the member is legally entitled to services and for which facilities are reasonably accessible to the member.
Q. Services on which claim is based from care which is received in a veteran's, marine or other federal hospital.
R. Non-medical ancillary services and long-term rehabilitative services for the treatment of alcoholism or drug abuse, including rehabilitation services in a specialized inpatient or residential facility.

BASIC
SCOPE OF BENEFITS

WHAT IS NOT COVERED (Cont'd)

S. Examinations specifically for the purpose of obtaining employment or insurance or examination precedent to engaging in recreational activities unless obtained in the context of periodic exam.
T. Care for conditions that federal, state or local law requires be treated in a public facility.
U. Services which in the judgment of a partricipating physician are not reasonably or medically necessary or not required in accordance with accepted standards of medical practice.
V. Eductation therapy and long-term speech therapy.
W. Routine foot care..
X. Vision care benefits or orthoptics, vision training, low vision aids, and any services or supplies determined by the plan to be special or unusual.
Y. Any types of services, supplies or treatment not specifically provided herein.
Z. Services rendered prior to your effective date of coverage or after your coverage terminates.
AA. Illnesses or injuries that are a result of war, declared or undeclared, or any act of war.
AB. Rental or purchase of durable medical equipment.
AC. Prosthetic and orthopedic appliances.
). Services that would have been payable under other contracts had the person followed the other contract's prescribed procedure for obtaining health care services or coverage.
AE. Services received from a member of the immediate family or rendered by a physician or another provider to himself or herself.
AF. Any service to the extent payment has been made under Medicare, or would have been made if the member had applied for Medicare and claimed Medicare benefits.
AG. Services that are for any illness or injury occurring in the course of employment if whole or partial compensation is available under Worker's Compensation laws or the laws of any governmental entity. (This does not apply where a sole proprietor or partner has elected not to be covered by the provisions of the Worker's Compensations Act.)
AH. Any service for which the member has no legal obligation to pay in the absence of this or similar coverage.
AI. Treatment of obesity or for weight reductions.
AJ. Outpatient prescription drugs.

IMPORTANT NOTICE: Although a specific service may be listed as a benefit, it will not be provided unless in the judgment of the Plan doctor, it is medically necessary for the prevention, diagnosis, or treatment of illness, injury or condition.

This document does not alter any of the terms or conditions of the subscriber contract.

HMO

STANDARD SCOPE OF BENEFITS

ALL CARE MUST BE RENDERED OR REFERRED BY THE PRIMARY CARE PHYSICIAN FOR THE CHARGES TO BE PAID BY THIS HEALTH CARE PLAN.

BENEFITS (subject to conditions & exclusions listed elsewhere)	**PLAN PAYS**
INPATIENT HOSPITAL SERVICES	
Room and Board	*80% Semi-Private
Length of Stay	Unlimited
Charges other than room and board	*80%
INPATIENT HOSPITAL PHYSICIAN SERVICES	
Any services rendered by the Primary Care Physician or by a Consultant when referred by the Primary Care Physician	100%
OUTPATIENT SURGERY PHYSICIAN SERVICES	100%
EMERGENCY ROOM SERVICES	*80% after $25.00 Copay
INPATIENT PRIVATE DUTY NURSING	
When medically necessary and authorized by this Plan's Medical Director	*80%
OUTPATIENT HOSPITAL SERVICES	*80%
Including Ambulatory Surgical Centers	
MEDICAL OFFICE VISITS	100% after $10.00 Copay
PREVENTIVE HEALTH SERVICES	
Well-baby care, routine exams, family planning, routine gynecological exams, vision and hearing screening through age 17	100% after $10.00 Copay
IMMUNIZATIONS	100%
ALLERGY TESTING	100% after $10.00 Copay
Allergy injections and allergens	100%
MATERNITY CARE	
Hospital Services	*Paid as any other condition
Physician Services	100% after $10.00 Copay
HOME HEALTH CARE	
Services are covered when medically necessary	100% after $10.00 Copay
OUTPATIENT MENTAL HEALTH SERVICES	
Up to 20 visits per calendar year	100% after $50.00 Copay
REHABILITATION SERVICES	
Short-term therapy when prescribed by the Primary Care Physician	*80%
SERVICES FOR ALCOHOL and DRUG ABUSE	
Acute Detoxification Stage Only	*80%
SKILLED NURSING FACILITY	
Up to 60 days per calendar year	*80%
AMBULANCE SERVICES	
Ground service for emergency	*80%

STANDARD SCOPE OF BENEFITS

Prescription Drugs	50% copay per 30 day supply
X-Ray and Laboratory Test	*80%
Including pap test and mammograms	
Hospice Care	*80%
Physical, Occupational & Speech Therapy	$15 per visit up to 2 months
When necessary and authorized by this Plan's Medical Director	

*For these services the employee pays 20% of the first $10,000 ($2,000) per member per calendar year. For the remainder of that year, benefits are paid at 100%.

WHAT IS NOT COVERED

A. Services of non-participating providers, except in an emergency or for out-of-area benefits, or when authorized in advance in writing by this plan.
B. Services and treatment of mental retardation and other mental health services, except as otherwise provided in Part V (J).
C. Eyeglasses, contact lenses, hearing aids and other vision care services, except medical services required for diagnosis and treatment of diseases of, or injury to, the eyes or ears, and Preventive Health Services for children through age 17.
D. Cosmetic or reconstructive surgery, unless deemed medically necessary by a participating physician with the prior approval of this plan to restore normal physiological functioning, or to correct a congenital condition.
E. Outpatient private duty nursing.
F. Non-prescription drugs, medications and contraceptive devices, including birth control pills.
G. Personal comfort items (such as radio, television, telephone and guest meals); private rooms, unless necessary during inpatient hospitalization.
H. Custodial or domiciliary care, or convalescent care not requiring skilled nursing in the opinion of the participating physician.
I. All dental services, except oral surgery.
J. Ambulance service, unless medically necessary.
K. Long-term physical therapy and rehabilitation services.
L. Medical, surgical, or other health care procedures deemed to be experimental by the Department of Health and Human Services.
M. Reversals of voluntarily induced infertility and in vitro fertilization procedures.
N. Elective abortions.
O. Procedures, services, and supplies related to sex transformations.
P. Care for military service-connected disabilities for which the member is legally entitled to services and for which facilities are reasonably accessible to the member.
Q. Services on which claim is based from care which is received in a veteran's, marine or other federal hospital.
R. Non-medical ancillary services and long-term rehabilitative services for the treatment of alcoholism or drug abuse, including rehabilitation services in a specialized inpatient or residential facility.

STANDARD
SCOPE OF BENEFITS

WHAT IS NOT COVERED (Cont'd)

S. Examinations specifically for the purpose of obtaining employment or insurance or examination precedent to engaging in recreational activities unless obtained in the context of periodic exam.
T. Care for conditions that federal, state or local law requires be treated in a public facility.
U. Services which in the judgment of a partricipating physician are not reasonably or medically necessary or not required in accordance with accepted standards of medical practice.
V. Eductation therapy and long-term speech therapy.
W. Routine foot care.
X. Vision care benefits or orthoptics, vision training, low vision aids, and any services or supplies determined by the plan to be special or unusual.
Y. Any types of services, supplies or treatment not specifically provided herein.
Z. Services rendered prior to your effective date of coverage or after your coverage terminates.
AA. Illnesses or injuries that are a result of war, declared or undeclared, or any act of war.
AB. Rental or purchase of durable medical equipment.
AC. Prosthetic and orthopedic appliances.
AD. Services that would have been payable under other contracts had the person followed the other contract's prescribed procedure for obtaining health care services or coverage.
AE. Services received from a member of the immediate family or rendered by a physician or another provider to himself or herself.
AF. Any service to the extent payment has been made under Medicare, or would have been made if the member had applied for Medicare and claimed Medicare benefits.
AG. Services that are for any illness or injury occurring in the course of employment if whole or partial compensation is available under Worker's Compensation laws or the laws of any governmental entity. (This does not apply where a sole proprietor or partner has elected not to be covered by the provisions of the Worker's Compensations Act.)
AH. Any service for which the member has no legal obligation to pay in the absence of this or similar coverage.
AI. Treatment of obesity or for weight reductions.

IMPORTANT NOTICE: Although a specific service may be listed as a benefit, it will not be provided unless in the judgment of the Plan doctor, it is medically necessary for the prevention, diagnosis, or treatment of illness, injury or condition.

This document does not alter any of the terms or conditions of the subscriber contract.