Open Access Health Network Option

INNOVATION HEALTH PLAN, INC.

Prepared exclusively for:
Contract holder: SAMPLE CO., INC.
Contract holder number: SAMPLE
Group agreement effective date: SAMPLE
Plan effective dates: SAMPLE

Underwritten by Innovation Health Plan, Inc. in the Commonwealth of Virginia

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-888-877-0943.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Innovation Health complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call 1-888-877-0943.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512,
1-800-648-7817, TTY: 711,
Fax: 859-425-3379,CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Innovation Health is the brand name used for products and services provided by Innovation Health Insurance Company and/or Innovation Health Plan, Inc. Innovation Health is an affiliate of Inova Health System and of one or more of Aetna group of subsidiary companies. Aetna and its affiliates provide certain management services to Innovation Health.

Language Assistance

TTY: 711

To access language services at no cost to you, call 1-888-877-0943.

Para acceder a los servicios de idiomas sin costo, llame al 1-888-877-0943. (Spanish)

如欲使用免費語言服務，請致電 1-888-877-0943。(Chinese)

Afin d'accéder aux services langagiers sans frais, composez le 1-888-877-0943. (French)

Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-888-877-0943. (Tagalog)

T'áá ni nizaad k'ehjí bee níká a'doowoł doo bááh ílínígóó koji' hólne' 1-888-877-0943. (Navajo)

Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-888-877-0943 an. (German)

Për shërbime përkthimi falas për ju, telefononi 1-888-877-0943. (Albanian)

የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-888-877-0943 ይደውሉ። (Amharic)

للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1-888-877-0943. (Arabic)

Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-888-877-0943 հեռախոսահամարով: (Armenian)

Kugira uronke serivisi z'indimi atakiguzi, hamagara 1-888-877-0943 (Bantu)

আপনাকে বিনামূল্যে ভাষা পরিষেবা পেতে হলে এই নম্বরে টেলিফোন করুন: 1-888-877-0943। (Bengali)

Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa1-888-877-0943. (Bisayan-Visayan)

သင့်အနေဖြင့် အခကြေးငွေ မပေးရပဲ ဘာသာစကားဝန်ဆောင်မှုများ ရရှိနိုင်ရန် 1-888-877-0943 သို့ ဖုန်းခေါ်ဆိုပါ။ (Burmese)

Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-888-877-0943. (Catalan)

Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-888-877-0943. (Chamorro)

ᏩᎩᏍᏗ ᏚᏬᏂᎯᏍᏗ ᎤᏳᎾᏝᏛᏁᏗ Ꮭ ᎪᎱᏍᏗ ᏗᏣᎬᏩᎶᏁᏗ ᏱᎩ, ᏫᏘᏯᏏᎳᏛᏍ 1-888-877-0943. (Cherokee)

Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-888-877-0943. (Choctaw)

Tajaajiiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-888-877-0943. (Cushite-Oromo)

Voor gratis toegang tot taaldiensten, bell 1-888-877-0943. (Dutch)

Pou jwenn sèvis lang gratis, rele 1-888-877-0943. (French Creole-Haitian)

Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-888-877-0943. (Greek)

તમારે કોઇ જાતના ખર્ચ વિના ભાષાની સેવાઓની પહોંચ માટે, કોલ કરો 1-888-877-0943. (Gujarati)

No ka wala‘au ‘ana me ka lawelawe ‘ōlelo e kahea aku i kēia helu kelepona 1-888-877-0943. Kāki ‘ole ‘ia kēia kōkua nei. (Hawaiian)

आपके लिए बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, 1-888-877-0943 पर कॉल करें। (Hindi)

Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-888-877-0943. (Hmong)

Iji nwetaòhèrè na ọrụ gasị asụsụ n'efu, kpọọ 1-888-877-0943. (Ibo)

Tapno maaksesyo dagiti serbisio maipapan iti pagsasao nga awan ti bayadanyo, tawagan ti 1-888-877-0943. (Ilocano)

Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi 1-888-877-0943. (Indonesian)

Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-888-877-0943 (Italian)

言語サービスを無料でご利用いただくには、1-888-877-0943 までお電話ください。(Japanese)

လာတ်ကမၤနှၤ်ကျိာ်အတ်မၤစၢၤအတ်ဖံးတ်မၤတဖျဲလၢတအိဉ်ဒီးအပူၤလၢကဘဉ်ဟုဉ်အီၤအဂီၢ်ဘဉ်နှဉ် ကိး 1-888-877-0943 တက့ၢ်. (Karen)

무료 언어 서비스를 이용하려면 1-888-877-0943 번으로 전화해 주십시오. (Korean)

Ǹ dyi wuɖu-dù kà kò ɖò ɓě dyi mɔ́uń nì Pídyi ní, nìí, ɖá nɔ̀ɓà nìà kɛ: 1-888-877-0943. (Kru-Bassa)

بۆ دەستپێڕاگەیشتن بە خزمەتگوزاری زمان بەبێ تێچوون بۆ تۆ، پەیوەندی بکە بە ژمارەی 1-888-877-0943. (Kurdish)

ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໂທຫາເບີ 1-888-877-0943. (Laotian)

कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-888-877-0943 वर फोन करा. (Marathi)

Nan etal nan jikin jiban ikijen Kajin ilo an ejelok onen nan kwe, kirlok 1-888-877-0943. (Marshallese)

Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih 1-888-877-0943. (Micronesian-Pohnpeian)

ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់ លេខ 1-888-877-0943។ (Mon-Khmer, Cambodian)

निःशुल्क भाषा सेवा प्राप्त गर्न 1-888-877-0943 मा टेलिफोन गर्नुहोस् । (Nepali)

Të kɔɔr yïn wëër de thokic ke cïn wëu kɔr keek tënɔŋ yïn. Ke cɔl kɔc ye kɔc kuɔny ne nɔmba 1-888-877-0943. (Nilotic-Dinka)

For tilgang til kostnadsfri språktjenester, ring 1-888-877-0943. (Norwegian)

Um Schprooch Services zu griege mitaus Koscht, ruff 1-888-877-0943. (Pennsylvania Dutch)

برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-888-877-0943 تماس بگیرید. (Persian-Farsi)

Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-888-877-0943 (Polish)

Para acessar os serviços de idiomas sem custo para você, ligue para 1-888-877-0943. (Portuguese)

ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, 1-888-877-0943 'ਤੇ ਫ਼ੋਨ ਕਰੋ। (Punjabi)

Pentru a accesa gratuit serviciile de limbă, apelați 1-888-877-0943. (Romanian)

Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-888-877-0943. (Russian)

Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala'au le 1-888-877-0943. (Samoan)

Za besplatne prevodilačke usluge pozovite 1-888-877-0943. (Serbo-Croatian)

Heeba a nasta jangirde djey wolde wola chede bo apelou lamba 1-888-877-0943. (Sudanic-Fulfulde)

Kupata huduma za lugha bila malipo kwako, piga 1-888-877-0943. (Swahili)

[illegible]

(Syriac-Assyrian) 1-888-877-0943

మీరు భాష సేవలను ఉచితంగా అందుకునేందుకు, 1-888-877-0943 కు కాల్ చేయండి. (Telugu)

หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-888-877-0943 (Thai)

Kapau 'oku ke fiema'u ta'etōtōngi 'a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he 1-888-877-0943. (Tongan)

Ren omw kopwe angei aninisin eman chon awewei (ese kamo), kopwe kori 1-888-877-0943. (Trukese)

Sizin için ücretsiz dil hizmetlerine erişebilmek için, 1-888-877-0943 numarayı arayın. (Turkish)

Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-888-877-0943. (Ukrainian)

بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-888-877-0943. پر بات کریں۔ (Urdu)

Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-888-877-0943. (Vietnamese)

צו צוטריט שפּראַך באַדינונגען אין קיין פּרייַז צו איר, רופן 1-888-877-0943. (Yiddish)

Lati wọnú awọn isẹ èdè l'ọfẹ fun ọ, pe 1-888-877-0943. (Yoruba)

Table of contents

Welcome

Thank you for choosing Innovation Health Plan, Inc. ("Innovation Health"). Welcome to your Innovation Health plan.

Introduction

This is your certificate of coverage or "certificate." It describes your **covered services** – what they are and how to get them. The schedule of benefits tells you how we share expenses for **covered services** and explains any limits. Along with the group agreement, they describe your Innovation Health plan. Each may have riders or amendments attached to them, which may change or add to the documents. This certificate takes the place of any others sent to you before. These documents are the entire contract between us and you. No part of the charter, bylaws or other document is part of the contract unless stated in the contract.

It's important that you read the entire certificate and your schedule of benefits. If you need help or more information, see the *Contact us* section below.

How we use words

When we use:

- "You" and "your" we mean you and any covered dependents (if your plan allows dependent coverage)
- "Us," "we," and "our" we mean Innovation Health Plan, Inc., the Health Maintenance Organization
- Words that are in bold, we define them in the *Glossary* section

Contact us

If you need to contact someone about this plan for any reason, please contact your agent. If no agent was involved in the sale of this plan, or if you have additional questions about your plan, you can contact us by:

- Calling us at 1-855-228-0510
- Logging on to the website at https://www.innovationhealth.com/
- Writing us at 3190 Fairview Park Drive, 5th floor, Suite 570, Falls Church, Virginia 22042

Your secure member website is available 24/7. With your member website, you can:

- See your coverage, benefits and costs
- Print an ID card and various forms
- Find a **provider**, research **providers**, care and treatment options
- View and manage claims
- Find information on health and wellness

If you have been unable to contact or obtain satisfaction from us or the agent, you can contact the Virginia State Corporation Commission's Bureau of Insurance at:

Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218

(804) 371-9741, local
(800) 552-7945, in-state toll-free number
(877) 310-6560, national toll-free number

Written correspondence is preferable to that a record of your inquiry is maintained. When contacting us, the agent or the BOI, have your policy number available.

We recommend you review our complaint and appeals procedures and make use of them before taking any other action.

About us

Innovation Health is subject to regulation in this Commonwealth by the State Corporation Commission Bureau of Insurance pursuant to Title 38.2 and by the Virginia Department of Health pursuant to Title 32.1.

Your ID card

Show your ID card each time you get **covered services** from a **provider**. Only members on your plan can use your ID card. We will mail you your ID card. If you haven't received it before you need **covered services**, or if you lose it, you can print a temporary one using the Innovation Health secure website.

Wellness and other rewards

You may be eligible to earn rewards for completing certain activities that improve your health, coverage, and experience with us. We may encourage you to access certain health services, participate in programs, including but not limited to financial wellness programs; utilize tools, improve your health metrics or continue participation as our member through incentives. Talk with your **provider** about these and see if they are right for you. We may provide incentives based on your participation and outcomes such as:

- Modifications to **copayment**, **deductible**, or **coinsurance** amounts
- Contributions to a health savings account
- Merchandise
- Coupons
- Gift cards or debit cards
- Any combination of the above

Coverage and exclusions

Providing covered services

Your plan provides **covered services**. These are:

- Described in this section.
- Not listed as an exclusion in this section or the *General plan exclusions* section.
- Not beyond any limits in the schedule of benefits.
- **Medically necessary**. See the *How your plan works – Medical necessity and precertification requirements* section and the *Glossary* for more information.

This plan provides coverage for many kinds of **covered services**, such as a doctor's care and **hospital stays**, but some services aren't covered at all or are limited. For other services, the plan pays more of the expense. For example:

- **Physician** care generally is covered but **physician** care for cosmetic **surgery** is an exclusion and not covered, except where described in *Coverage and exclusions* under the *Reconstructive breast surgery and supplies* and *Reconstructive surgery and supplies* sections.
- Home health care is generally covered but it is a **covered service** only up to a set number of visits a year. This is a limitation.
- Preventive services. Usually the plan pays more and you pay less. Preventive services are designed to help keep you healthy, supporting you in achieving your best health. To find out what these services are, see the *Preventive care* section in the list of services below. To find out how much you will pay for these services, see *Preventive care* in your schedule of benefits.

Some services require **precertification** from us. For more information see the *How your plan works – Medical necessity and precertification requirements* section.

The **covered services** and exclusions below appear alphabetically to make it easier to find what you're looking for. You can find out about limitations for **covered services** in the schedule of benefits. If you have questions, contact us.

Acupuncture

Covered services include acupuncture services provided by a **physician**, if the service is provided as a form of anesthesia in connection with a covered **surgical procedure**.

Covered services also include services performed to alleviate, treat, or limit:

- Chronic pain
- Postoperative and chemotherapy-induced nausea and vomiting
- Nausea during pregnancy
- Postoperative dental pain
- Temporomandibular disorders (TMD)
- Migraine headache
- Pain from osteoarthritis of the knee or hip

The following are not **covered services**:

- Acupressure

Ambulance services

An ambulance is a vehicle staffed by medical personnel and equipped to transport an ill or injured person.

Emergency

Covered services include emergency transport to a **hospital** by a licensed ambulance:

- To the first **hospital** to provide **emergency services**
- From one **hospital** to another if the first **hospital** can't provide the **emergency services** you need
- When your condition is unstable and requires medical supervision and rapid transport

Non-emergency

Covered services also include precertified transportation to a **hospital** by a licensed ambulance:

- From a **hospital** to your home or to another facility if an ambulance is the only safe way to transport you
- From your home to a **hospital** if an ambulance is the only safe way to transport you; limited to 100 miles
- When during a covered inpatient **stay** at a **hospital**, **skilled nursing facility** or acute rehabilitation **hospital**, an ambulance is required to safely and adequately transport you to or from inpatient or outpatient treatment

The following are not **covered services**:

- Non-emergency airplane transportation by an **out-of-network provider**
- Ambulance services for routine transportation to receive outpatient or inpatient services

Applied behavior analysis

Covered services include certain early intensive behavioral interventions such as applied behavior analysis. Applied Behavioral Analysis is 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.

Important note:
Applied behavior analysis may require **precertification** by us. See the *How your plan works – Medical necessity and precertification* section.

The following are not **covered services**:

- Early intensive behavioral interventions, such as Denver, LEAP, TEACCH, Rutgers, floor time, Lovaas and similar programs, and other intensive educational interventions

Autism spectrum disorder

Autism spectrum disorder is defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association. It includes:

- Autistic disorder
- Asperger's syndrome
- Rett's syndrome

- Childhood disintegrative disorder
- Pervasive developmental disorder not otherwise specified

Covered services include services and supplies provided by a **physician** or **behavioral health provider** for the diagnosis and treatment of autism spectrum disorder. We will only cover this treatment if a **physician** or **behavioral health provider** orders it as part of a treatment plan which they develop:

- Following a complete evaluation or reevaluation
- In accordance with the most recent clinical report or recommendation of one of the following:
  - American Academy of Pediatrics
  - American Academy of Child and Adolescent Psychiatry

The care within a treatment plan includes:

- Behavioral health treatment
- Pharmacy care
- Psychiatric care
- Psychological care
- Therapeutic care
- Applied behavior analysis

Clinical trials

Routine patient costs

Covered services include routine patient costs you have from a **provider** in connection with participation in an approved clinical trial as a qualified individual for cancer or other life-threatening disease or condition.

"Routine patient cost" means the cost of a health care service incurred as a result of treatment being provided to the covered person for purposes of a clinical trial.

"Life threatening condition" means any disease or condition from which death is likely unless the course of disease or condition is interrupted.

"Qualified individual" means a covered person who is eligible to participate in an approved clinical trial according to the trial protocol, with respect to treatment of cancer or other life-threatening disease or condition, and the referring health care professional has concluded that the individual's participation in such trial is appropriate to treat the disease or condition, or the individual's participation is based on medical and scientific information.

The following are not **covered services**:

- Services and supplies related to data collection and record-keeping needed only for the clinical trial
- Services and supplies provided by the trial sponsor for free
- Services that are clearly inconsistent with widely accepted and established standards of care for a particular diagnosis
- The experimental intervention itself (except Category B investigational devices and promising experimental and investigational interventions for **terminal illnesses** in certain clinical trials in accordance with our policies)

Experimental or investigational therapies

Covered services include drugs, devices, treatments, or procedures from a **provider** under an "approved clinical trial". All of the following conditions must be met:

- Standard therapies have not been effective or are not appropriate
- We determine you may benefit from the treatment

An approved clinical trial is a phase I, phase II, phase III or phase IV clinical trial conducted to prevent, detect, or treat cancer or other life-threatening disease or condition. It must meet all of these requirements:

- The clinical trial is a federally funded or approved trial
- The clinical trial is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration, or is a drug trial that is exempt from having an investigational new drug application

Dental anesthesia

Covered services include anesthesia, hospitalization, professional and facility charges for dental care if:

- Your **provider** determines that you require general anesthesia and admission to a hospital or outpatient surgery center to effectively and safely provide the underlying dental care; and
- You are severely disabled; or
- You have a medical need for general anesthesia; or
- You are under 5 years old

For purposes of this review, a determination of **medical necessity** shall include but not be limited to a consideration of whether your age, physical condition or mental condition requires the utilization of general anesthesia and the admission to a **hospital** or outpatient surgery center to safely provide the underlying dental care.

Dental injury

Covered services include **medically necessary** dental services to repair natural teeth damaged or lost due to accidental injury, regardless of the date of the injury. However, we may require you get treatment within 60 days of the accident for injuries that occur on or after the effective date of coverage.

Diabetic services, supplies, equipment, and education

Covered services include:

- Services
  - Foot care to minimize the risk of infection
- Supplies
  - Injection devices including syringes, needles and pens
  - Test strips - blood glucose, ketone and urine
  - Blood glucose calibration liquid
  - Lancet devices and kits
  - Alcohol swabs
- Equipment
  - External insulin pumps and pump supplies
  - Blood glucose monitors without special features, unless required due to blindness

- Education
- Self-management training, which includes medical nutritional therapy provided by a health care **provider** certified in diabetes self-management training

Durable medical equipment (DME)

DME and the accessories needed to operate it are:

- Made to withstand prolonged use
- Mainly used in the treatment of illness or injury
- Suited for use in the home
- Not normally used by people who do not have an illness or injury
- Not for altering air quality or temperature
- Not for exercise or training

Your plan only covers the same type of DME that Medicare covers. But there are some DME items Medicare covers that your plan does not.

Covered services include the expense of renting or buying DME and accessories you need to operate the item from a DME supplier. If you purchase DME, that purchase is only covered if you need it for long-term use.

Covered services also include:

- One item of DME for the same or similar purpose
- Repairing DME due to normal wear and tear
- A new DME item you need because your physical condition has changed
- Buying a new DME item to replace one that was damaged due to normal wear, if it would be cheaper than repairing it or renting a similar item

The following are not **covered services**:

- Communication aid
- Elevator
- Maintenance and repairs that result from misuse or abuse
- Massage table
- Message device (personal voice recorder)
- Over bed table
- Portable whirlpool pump
- Sauna bath
- Telephone alert system
- Vision aid
- Whirlpool

Emergency services

When you experience an **emergency medical condition**, you should go to the nearest emergency room. You can also dial 911 or your local emergency response service for medical and ambulance help.

Covered services include only outpatient services to evaluate and stabilize an **emergency medical condition** in a **hospital** emergency room. You can get **emergency services** from **network providers** or **out-of-network providers**.

If your **physician** decides you need to stay in the **hospital** (emergency admission) or receive follow-up care, these are not **emergency services**. Different benefits and requirements apply. Please refer to the *How your plan works – Medical necessity and precertification requirements* section and the *Coverage and exclusions* section that fits your situation (for example, *Hospital care* or *Physician services*). You can also contact us or your network **physician** or **primary care physician** (**PCP**).

Non-emergency services
If you go to an emergency room for what is not an **emergency medical condition**, the plan may not cover your expenses. See the schedule of benefits for this information.

Habilitation therapy services

Habilitation therapy services help you keep, learn, or improve skills and functioning for daily living (e.g. therapy for a child who isn't walking or talking at the expected age). The services must follow a specific treatment plan, ordered by your **physician**. The services have to be performed by a:

- Licensed or certified physical, occupational, or speech therapist
- **Hospital**, **skilled nursing facility**, or hospice facility
- **Home health care agency**
- **Physician**

Outpatient physical, occupational, and speech therapy

Covered services include:

- Physical therapy if it is expected to develop any impaired function
- Occupational therapy if it is expected to develop any impaired function
- Speech therapy if it is expected to develop speech function that resulted from delayed development

(Speech function is the ability to express thoughts, speak words and form sentences.)

The following are not **covered services**:

- Services provided in an educational or training setting or to teach sign language
- Vocational rehabilitation or employment counseling

Hearing exams

Covered services include hearing exams for evaluation and treatment of hearing loss when performed by a hearing **specialist**.

The following are not **covered services**:

- Hearing exams given during a **stay** in a **hospital** or other facility, except those provided to newborns as part of the overall **hospital stay**

Hemophilia and congenital bleeding disorders

Covered services for home treatment of routine bleeding episodes associated with hemophilia and other congenital bleeding disorders include:

- Blood infusion equipment, including but not limited to, syringes and needles
- Blood products, including but not limited to, Factor VII, Factor VIII, Factor IX and cryoprecipitate
- Training to provide infusion therapy at home

The home treatment must be supervised by a state-approved hemophilia treatment center.

Home health care

Covered services include home health care provided by a **home health care agency** in the home, or via remote patient monitoring, but only when all of the following criteria are met:

- You are homebound
- Your **physician** orders them
- The services take the place of a **stay** in a **hospital** or a **skilled nursing facility**, or you are unable to receive the same services outside your home
- The services are a part of a home health care plan
- The services are **skilled nursing services**, home health aide services or medical social services, or are short-term speech, physical or occupational therapy
- Home health aide services are provided under the supervision of a registered nurse
- Medical social services are provided by or supervised by a **physician** or social worker

Remote patient monitoring services means the delivery of home health services using telecommunications technology, including:

- Monitoring clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose, and other condition-specific data
- Medication adherence monitoring
- Interactive video conferencing with or without digital image upload

If you are discharged from a **hospital** or **skilled nursing facility** after a **stay**, the intermittent requirement may be waived to allow coverage for continuous **skilled nursing services**. See the schedule of benefits for more information on the intermittent requirement.

Short-term physical, speech, and occupational therapy provided in the home are subject to the same conditions and limitations imposed on therapy provided outside the home. See *Rehabilitation services* and *Habilitation therapy services* in this section and the schedule of benefits.

The following are not **covered services**:

- Custodial care
- Services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities)
- Transportation
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present

Hospice care

Covered services include inpatient and outpatient and home hospice care when given as part of a hospice care program. The types of hospice care services that are eligible for coverage include:

- **Room and board**
- Services and supplies furnished to you on an inpatient or outpatient or home basis
- Services by a hospice care agency or hospice care provided in a **hospital**
- Psychological and dietary counseling
- Pain management and symptom control
- Bereavement counseling
- Respite and palliative care

The following are not **covered services**:

- Funeral arrangements
- Pastoral counseling
- Financial or legal counseling including estate planning and the drafting of a will
- Homemaker services, caretaker services, or any other services not solely related to your care, which may include:
    - Sitter or companion services for you or other family members
    - Transportation
    - Maintenance of the house

Hospital care

Covered services include inpatient and outpatient **hospital** care. This includes:

- Semi-private **room and board**. Your plan will cover the extra expense of a private room when appropriate because of your medical condition.
- Services and supplies provided by the outpatient department of a **hospital**, including the facility charge.
- Services of **physicians** employed by the **hospital**.
- Administration of blood and blood derivatives, but not the expense of the blood or blood product, unless they are:
    - **Medically necessary** and you incur a charge for the expense
    - For the treatment of hemophilia and congenital bleeding disorders (See **Hemophilia and congenital bleeding disorders** above for more information).
- Services and supplies for a hysterectomy, for a minimum stay of not less than:
    - 23 hours following a laparoscopy-assisted vaginal hysterectomy
    - 48 hours following a vaginal hysterectomy

  A shorter inpatient stay will be allowed if the attending **provider** and you determine that a shorter length of stay is appropriate.
- Services for:
    - General nursing care
    - Special diets
    - Biologicals
    - Anesthesia
    - Oxygen
    - Special duty nursing

The following are not **covered services**:

- All services and supplies provided in:
  - Rest homes
  - Any place considered a person's main residence or providing mainly custodial or rest care
  - Health resorts
  - Spas
  - Schools or camps

Infertility services

Covered services include seeing a **network provider**:

- To diagnose and evaluate the underlying medical cause of **infertility**.
- To do **surgery** to treat the underlying medical cause of **infertility**. Examples are endometriosis **surgery** or, for men, varicocele **surgery**.

The following are not **covered services**:

- All **infertility** services associated with or in support of an injectable drug (menotropin) cycle, including, but not limited to, imaging, laboratory services, professional services.
- Intrauterine/intracervical insemination services.
- All **infertility** services associated with or in support of an Assisted Reproductive Technology (ART) cycle. These include, but are not limited to:
  - Imaging, laboratory services, professional services
  - In vitro fertilization (IVF)
  - Zygote intrafallopian transfer (ZIFT)
  - Gamete intrafallopian transfer (GIFT)
  - Cryopreserved embryo transfers
  - Gestational carrier cycles
  - Any related services, products or procedures (such as intracytoplasmic sperm injection (ICSI) or ovum microsurgery)
- Cryopreservation (freezing), storage or thawing of eggs, embryos, sperm or reproductive tissue.
- All charges associated with or in support of surrogacy arrangements for you or the surrogate. A surrogate is a female carrying her own genetically related child with the intention of the child being raised by someone else, including the biological father.
- Home ovulation prediction kits or home pregnancy tests.
- The purchase of donor embryos, donor oocytes or donor sperm.

Jaw joint disorder treatment

Covered services include the diagnosis and surgical treatment of **jaw joint disorder** by a **provider**, including:

- The jaw joint itself, such as temporomandibular joint dysfunction (TMJ) syndrome
- The relationship between the jaw joint and related muscle and nerves, such as myofascial pain dysfunction (MPD)

The following are not **covered services**:

- Non-surgical medical and dental services, and therapeutic services related to **jaw joint disorder**

Lymphedema

Covered services include the diagnosis, evaluation, and treatment of lymphedema, including:

- Equipment
- Supplies
- Complex decongestive therapy
- Self-management training and education by a licensed **health professional**

Maternity and related newborn care

Covered services include pregnancy (prenatal) care, care after delivery and obstetrical services. After your child is born, **covered services** include:

- No less than 48 hours of inpatient care in a **hospital** after a vaginal delivery
- No less than 96 hours of inpatient care in a **hospital** after a cesarean delivery
- A shorter **stay**, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier

Covered services also include services and supplies needed for circumcision by a **provider**.

The following are not **covered services**:

- Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries

Mental health treatment

Covered services include the treatment of **mental disorders** provided by a **hospital**, **psychiatric hospital**, **residential treatment facility**, **physician,** or **behavioral health provider** including:

- Inpatient **room and board** at the **semi-private room rate**, and other services and supplies related to your condition that are provided during your **stay** in a **hospital**, **psychiatric hospital**, or **residential treatment facility**
- Outpatient treatment received while not confined as an inpatient in a **hospital**, **psychiatric hospital**, or **residential treatment facility**, including:
  - Office visits to a **physician** or **behavioral health provider** such as a psychiatrist, psychologist, social worker, or licensed professional counselor (includes **telemedicine** consultation)
  - Individual, group, and family therapies for the treatment of **mental disorders**
  - Other outpatient mental health treatment such as:
    - **Partial hospitalization treatment** provided in a facility or program for mental health treatment provided under the direction of a **physician**
    - Intensive outpatient program provided in a facility or program for mental health treatment provided under the direction of a **physician**
    - Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
      - You are homebound
      - Your **physician** orders them
      - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home

        - The skilled behavioral health care is appropriate for the active treatment of a condition, illness, or disease to avoid placing you at risk for serious complications
    - Electro-convulsive therapy (ECT)
    - Transcranial magnetic stimulation (TMS)
    - Psychological testing
    - Neuropsychological testing
    - 23 hour observation
    - Peer counseling support by a peer support specialist

A peer support specialist serves as a role model, mentor, coach and advocate. They must be certified by the state where the services are provided or by a private certifying organization recognized by us. Peer support must be supervised by a **behavioral health provider**.

Nutritional support

For purposes of this benefit, "low protein modified food product" means foods that are specifically formulated to have less than one gram of protein per serving and are intended to be used under the direction of a **physician** for the dietary treatment of any inherited metabolic disease. Low protein modified food products do not include foods that are naturally low in protein.

Covered services include formula and low protein modified food products ordered by a **physician** for the treatment of phenylketonuria or an inherited disease of amino and organic acids.

The following are not **covered services**:

- Any food item, including:
    - Infant formulas
    - Nutritional supplements
    - Vitamins
    - Medical foods
    - Other nutritional items

  even if it is the sole source of nutrition.

Outpatient surgery

Covered services include services provided and supplies used in connection with outpatient **surgery** performed in a **surgery** center or a **hospital's** outpatient department.

Important note:
Some **surgeries** can be done safely in a **physician's** office. For those **surgeries**, your plan will pay only for **physician**, **PCP** services and not for a separate fee for facilities.

The following are not **covered services**:

- A **stay** in a **hospital** (see *Hospital care* in this section)
- A separate facility charge for **surgery** performed in a **physician's** office
- Services of another **physician** for the administration of a local anesthetic

Physician services

Covered services include services by your **physician** to treat an illness or injury. You can get services:

- At the **physician's** office
- In your home
- In a **hospital**
- From any other inpatient or outpatient facility
- By way of **telemedicine**

Other services and supplies that your **physician** may provide:

- Allergy testing and allergy injections
- Radiological supplies, services, and tests
- Immunizations that are not covered as preventive care

Physician surgical services

Covered services include the services of:

- The surgeon who performs your **surgery**
- Your surgeon who you visit before and after the **surgery**
- Another surgeon who you go to for a second opinion before the **surgery**

The following are not **covered services**:

- A **stay** in a **hospital** (See *Hospital care* in this section)
- A separate facility charge for **surgery** performed in a **physician's** office
- Services of another **physician** for the administration of a local anesthetic

Preventive care

Preventive **covered services** are designed to help keep you healthy, supporting you in achieving your best health through early detection. If you need further services or testing such as diagnostic testing, you may pay more as these services aren't preventive. If a **covered service** isn't listed here under preventive care, it still may be covered under other **covered services** in this section. For more information, see your schedule of benefits.

The following agencies set forth the preventive care guidelines in this section:

- Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC)
- United States Preventive Services Task Force (USPSTF)
- Health Resources and Services Administration
- American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents

These recommendations and guidelines may be updated periodically. When updated, they will apply to this plan. The updates are effective on the first day of the year, one year after the updated recommendation or guideline is issued.

For frequencies and limits, contact your **physician** or us. This information is also available at https://www.healthcare.gov/.

Important note:
Gender-specific preventive care benefits include **covered services** described regardless of the sex you were assigned at birth, your gender identity, or your recorded gender.

Breast-feeding support and counseling services

Covered services include assistance and training in breast-feeding and counseling services during pregnancy or after delivery. Your plan will cover this counseling only when you get it from a certified breast-feeding support **provider**.

Breast pump, accessories and supplies

Covered services include renting or buying equipment you need to pump and store breast milk.

Coverage for the purchase of breast pump equipment is limited to one item of equipment, for the same or similar purpose, and the accessories and supplies needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

Counseling services

Covered services include preventive screening and counseling by your **health professional** for:

- Alcohol or drug misuse
  - Preventive counseling and risk factor reduction intervention
  - Structured assessment
- Genetic risk for breast and ovarian cancer
- Obesity and healthy diet
  - Preventive counseling and risk factor reduction intervention
  - Nutritional counseling
  - Healthy diet counseling provided in connection with hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease
- Sexually transmitted infection
- Tobacco cessation
  - Preventive counseling to help stop using tobacco products
  - Treatment visits
  - Class visits

Family planning services – female contraceptives

Covered services include family planning services as follows:

- Counseling services provided by a **physician** on contraceptive methods. These will be covered when you get them in either a group or individual setting.
- Contraceptive devices (including any related services or supplies) when they are provided, administered, or removed by a **physician** during an office visit.
- Voluntary sterilization including charges billed separately by the **provider** for female voluntary sterilization procedures and related services and supplies. This also could include tubal ligation and sterilization implants.

The following are not preventive **covered services**:

- Services provided as a result of complications resulting from a voluntary sterilization procedure and related follow-up care
- Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA
- Male contraceptive methods, sterilization procedures or devices

Immunizations

Covered services include preventive immunizations for infectious diseases.

The following are not preventive **covered services**:

- Immunizations that are not considered preventive care, such as those required due to your employment or travel

Prenatal care

Covered services include your routine pregnancy physical exams at the **physician**, **PCP**, OB, GYN or OB/GYN office. The exams include initial and subsequent visits for:

- Anemia screening
- Blood pressure
- Chlamydia infection screening
- Fetal heart rate check
- Fundal height
- Gestational diabetes screening
- Gonorrhea screening
- Hepatitis B screening
- Maternal weight
- Rh incompatibility screening

Routine cancer screenings

Covered services include the following routine cancer screenings:

- Colonoscopies including pre-procedure **specialist** consultation, removal of polyps during a screening procedure, and a pathology exam on any removed polyp
- Digital rectal exams (DRE)
- Double contrast barium enemas (DCBE)
- Fecal occult blood tests (FOBT)
- Lung cancer screenings
- Mammograms
- Prostate specific antigen (PSA) tests
- Sigmoidoscopies

Routine physical exams

A routine preventive exam is a medical exam given for a reason other than to diagnose or treat a suspected or identified illness or injury and also includes:

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.
- Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.

- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
    - Screening and counseling services on topics such as:
        - Interpersonal and domestic violence
        - Sexually transmitted diseases
        - Human immune deficiency virus (HIV) infections
    - High risk human papillomavirus (HPV) DNA testing for women

Covered services include:

- Annual routine office visit to a **physician**
- Hearing screening
- Vision screening
- Radiological services, lab and other tests
- For covered newborns, an initial **hospital** checkup

Well woman preventive visits

A routine well woman preventive exam is a medical exam given for a reason other than to diagnose or treat a suspected or identified illness or injury and also includes:

- Office visit to a **physician**, **PCP**, OB, GYN or OB/GYN for services including Pap smears
- Preventive care breast cancer (BRCA) gene blood testing
- Screening for diabetes after pregnancy for women with a history of diabetes during pregnancy
- Screening for urinary incontinence

Prosthetic device

A prosthetic device is a device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of illness, injury or congenital defects.

Covered services include the initial provision and subsequent replacement of a prosthetic device that your **physician** orders and administers.

Coverage includes:

- Instruction and other services (such as attachment or insertion) so you can properly use the device
- Repairing or replacing the original device you outgrow or that is no longer appropriate because your physical condition changed
- Replacements required by ordinary wear and tear or damage

The following are not **covered services**:

- Services covered under any other benefit
- Orthopedic shoes and therapeutic shoes, unless the orthopedic shoe is an integral part of a covered leg brace
- Trusses, corsets, and other support items
- Repair and replacement due to loss, misuse, abuse or theft

Reconstructive breast surgery and supplies

Covered services include all stages of reconstructive **surgery** by your **provider** and related supplies provided in an inpatient or outpatient setting only in the following circumstances:

- Your **surgery** reconstructs the breast where a necessary mastectomy was performed, such as an implant and areolar reconstruction. It also includes:
  - **Surgery** on a healthy breast to make it symmetrical with the reconstructed breast
  - Treatment of physical complications of all stages of the mastectomy, including lymphedema
  - Prostheses

Unless you and your **provider** decide that a shorter time period for inpatient care is appropriate, **covered services** for reconstructive breast surgery include:

- 48 hours of inpatient care following a mastectomy
- 24 hours of inpatient care in a network health care facility after a lymph node dissection for treatment of breast cancer

Reconstructive surgery and supplies

Covered services include all stages of reconstructive **surgery** by your **provider** and related supplies provided in an inpatient or outpatient setting only in the following circumstances:

- Your **surgery** is to implant or attach a covered prosthetic device.
- Your **surgery** corrects a birth defect. The **surgery** will be covered if:
  - The defect results in severe facial disfigurement or major functional impairment of a body part
  - The purpose of the **surgery** is to improve function
- Your **surgery** is needed because treatment of your illness resulted in severe facial disfigurement or major functional impairment of a body part, and your **surgery** will improve function.

Short-term cardiac and pulmonary rehabilitation services

Cardiac rehabilitation

Covered services include cardiac rehabilitation services you receive at a **hospital**, **skilled nursing facility** or **physician's** office, but only if those services are part of a treatment plan determined by your risk level and ordered by your **physician**.

Pulmonary rehabilitation

Covered services include pulmonary rehabilitation services as part of your inpatient **hospital stay** if they are part of a treatment plan ordered by your **physician**. A course of outpatient pulmonary rehabilitation may also be covered if it is performed at a **hospital**, **skilled nursing facility**, or **physician's** office and is part of a treatment plan ordered by your **physician**.

Short-term rehabilitation services

Short-term rehabilitation services help you restore or develop skills and functioning for daily living. The services must follow a specific treatment plan, ordered by your **physician**. The services have to be performed by a:

- Licensed or certified physical, occupational, or speech therapist
- **Hospital**, **skilled nursing facility**, or hospice facility

- **Home health care agency**
- **Physician**

Covered services also include spinal manipulation to correct a muscular or skeletal problem. Your **provider** must establish or approve a treatment plan that details the treatment and specifies frequency and duration.

Cognitive rehabilitation, physical, occupational, and speech therapy

Covered services include:

- Physical therapy, but only if it is expected to significantly improve or restore physical functions lost as a result of an acute illness, injury, or **surgical procedure**
- Occupational therapy, but only if it is expected to do one of the following:
  - Significantly improve, develop, or restore physical functions you lost as a result of an acute illness, injury, or **surgical procedure**
  - Help you relearn skills so you can significantly improve your ability to perform the activities of daily living on your own
- Speech therapy, but only if it is expected to do one of the following:
  - Significantly improve or restore lost speech function or correct a speech impairment resulting from an acute illness, injury, or **surgical procedure**
  - Improve delays in speech function development caused by a defect present at birth

  (Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.)
- Cognitive rehabilitation associated with physical rehabilitation, but only when:
  - Your cognitive deficits are caused by neurologic impairment due to trauma, stroke, or encephalopathy
  - The therapy is coordinated with us as part of a treatment plan intended to restore previous cognitive function

The following are not **covered services**:

- Services provided in an educational or training setting or to teach sign language
- Vocational rehabilitation or employment counseling

Early intervention services

Early intervention services are available to children from birth to age 3. They are services that help a child develop, learn or keep skills to function age appropriately within their home or normal everyday settings and shall include services that enhance functional ability without effecting a cure. To receive services, your child must be certified by the Department of Behavioral Health and Developmental Services as eligible for services under Part H of the Individuals with Disabilities Education Act.

Covered services include:

- Speech and language therapy
- Occupational therapy
- Physical therapy
- Assistive technology services and devices

Skilled nursing facility

Covered services include precertified inpatient **skilled nursing facility** care. This includes:

- **Room and board**, up to the **semi-private room rate**
- Services and supplies provided during a **stay** in a **skilled nursing facility**

Substance use disorders treatment

Covered services include the treatment of **substance use disorders** provided by a **hospital**, **psychiatric hospital**, **residential treatment facility**, **physician**, or **behavioral health provider** as follows:

- Inpatient **room and board**, at the **semi-private room rate** and other services and supplies that are provided during your **stay** in a **hospital**, **psychiatric hospital**, or **residential treatment facility**. Treatment of **substance use disorders** in a general medical **hospital** is only covered if you are admitted to the **hospital's** separate **substance use disorders** section or unit, unless you are admitted for the treatment of medical complications of **substance use disorders**.
- As used here, "medical complications" include, but are not limited to:
  - Electrolyte imbalances
  - Malnutrition
  - Cirrhosis of the liver
  - Delirium tremens
  - Hepatitis
- Outpatient treatment received while not confined as an inpatient in a **hospital**, **psychiatric hospital**, or **residential treatment facility**, including:
  - Office visits to a **physician** or **behavioral health provider** such as a psychologist, social worker, or licensed professional counselor (includes **telemedicine** consultation)
  - Individual, group, and family therapies for the treatment of **substance use disorders**
  - Other outpatient **substance use disorders** treatment such as:
    - **Partial hospitalization treatment** provided in a facility or program for treatment of **substance use disorders** provided under the direction of a **physician**
    - Intensive outpatient program provided in a facility or program for treatment of **substance use disorders** provided under the direction of a **physician**
    - Ambulatory or outpatient **detoxification** which include outpatient services that monitor withdrawal from alcohol or other substances, including administration of medications
    - 23 hour observation
    - Peer counseling support by a peer support specialist

A peer support specialist serves as a role model, mentor, coach, and advocate. They must be certified by the state where the services are provided or a private certifying organization recognized by us. Peer support must be supervised by a **behavioral health provider.**

Tests, images and labs – inpatient and outpatient

Diagnostic complex imaging services

Covered services include:

- Computed tomography (CT) scans, including for preoperative testing
- Magnetic resonance imaging (MRI) including magnetic resonance spectroscopy (MRS), magnetic resonance venography (MRV) and magnetic resonance angiogram (MRA)
- Nuclear medicine imaging including positron emission tomography (PET) scans

Complex imaging for preoperative testing is covered under this benefit.

Diagnostic lab work

Covered services include:

- Lab
- Pathology
- Other tests

These are covered only when you get them from a licensed radiology **provider** or lab.

Diagnostic x-ray and other radiological services

Covered services include x-rays, scans and other services (but not complex imaging) only when you get them from a licensed radiology **provider**. See *Diagnostic complex imaging services* above for more information.

Therapies – chemotherapy, infusion, radiation

Chemotherapy

Covered services for chemotherapy depend on where treatment is received. In most cases, chemotherapy is covered as outpatient care. However, your **hospital** benefit covers the initial dose of chemotherapy after a cancer diagnosis during a **hospital stay**.

Infusion therapy

Infusion therapy is the intravenous (IV) administration of prescribed medications or solutions. **Covered services** include infusion therapy you receive in an outpatient setting including but not limited to:

- A freestanding outpatient facility
- The outpatient department of a **hospital**
- A **physician's** office
- Your home from a home care **provider**

You can access the list of preferred infusion locations by contacting us.

When Infusion therapy services and supplies are provided in your home, they will not count toward any applicable home health care maximums.

Certain infused medications may be covered under the outpatient **prescription** drug rider. You can access the list of **specialty prescription drugs** by contacting us.

Radiation therapy

Covered services include the following radiology services provided by a **health professional**:

- Accelerated particles
- Gamma ray
- Mesons
- Neutrons
- Radioactive isotopes
- Radiological services

- Radium

Transplant services

Covered services include transplant services provided by a **physician** and **hospital**.

This includes the following transplant types:

- Solid organ
- Hematopoietic stem cell
- Bone marrow
- CAR-T and T-Cell receptor therapy for FDA-approved treatments

Network of transplant facilities

We designate facilities to provide specific services or procedures. They are listed as Institutes of Excellence™ (IOE) facilities in your **provider** directory.

You must get transplant services from the IOE facility we designate to perform the transplant you need.

Important note:

If there are no IOE facilities assigned to perform your transplant type in your network, the National Medical Excellence® (NME) program will arrange for and coordinate your care at an IOE facility in another one of our **provider** networks. If you don't get your transplant services at the IOE facility we designate, they will not be **covered services**.

Many pre and post transplant medical services, even routine ones, are related to and may affect the success of your transplant. While your transplant care is being coordinated by the National Medical Excellence® (NME) program, all medical services must be managed through NME so that you receive the highest level of benefits at the appropriate facility. This is true even if the **covered service** is not directly related to your transplant.

The following are not **covered services**:

- Services and supplies furnished to a donor when the recipient is not a covered person
- Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing illness
- Harvesting and/or storage of bone marrow, hematopoietic stem cells, or other blood cells without intending to use them for transplantation within 12 months from harvesting, for an existing illness

Urgent care services

Covered services include services and supplies to treat an **urgent condition** at an urgent care center. An "urgent care center" is a facility licensed as a freestanding medical facility to treat **urgent conditions**. **Urgent conditions** need prompt medical attention but are not life-threatening.

If you go to an urgent care center for what is not an **urgent condition**, the plan may not cover your expenses. See the schedule of benefits for more information.

Covered services include services and supplies to treat an **urgent condition** at an urgent care center as described below:

- **Urgent condition** within the service area
  - If you need care for an **urgent condition**, you should first seek care through your **physician**, **PCP**. If your **physician** is not reasonably available, you may access urgent care from an urgent care center within the service area.
- **Urgent condition** outside the service area
  - You are covered for urgent care obtained from a facility outside of the service area if you are temporarily absent from the service area and getting the health care service cannot be delayed until you return to the service area.

The following are not **covered services**:

- Non-urgent care in an urgent care center

Vision care

Adult vision care

Covered services include:

- Routine vision exam provided by an ophthalmologist or optometrist including refraction and glaucoma testing

The following are not **covered services**:

- Office visits to an ophthalmologist, optometrist or optician related to the fitting of **prescription** contact lenses
- Eyeglass frames, non-**prescription** lenses and non-**prescription** contact lenses that are for cosmetic purposes

Pediatric vision care

Covered services include:

- Routine vision exam provided by an ophthalmologist or optometrist including refraction and glaucoma testing

The following are not **covered services**:

- Office visits to an ophthalmologist, optometrist or optician related to the fitting of **prescription** contact lenses
- Eyeglass frames, non-**prescription** lenses and non-**prescription** contact lenses that are for cosmetic purposes

Walk-in clinic

Covered services include health care services provided at a **walk-in clinic** for:

- Unscheduled, non-medical emergency illnesses and injuries
- Immunizations administered within the scope of the clinic's license
- Individual screening and counseling services that will help you:
  - With obesity or healthy diet
  - To stop using tobacco products

General plan exclusions

The following are not **covered services** under your plan:

Blood, blood plasma, synthetic blood, blood derivatives or substitutes

Examples of these are:

- The provision of blood to the **hospital**, other than blood derived clotting factors
- Any related services including processing, storage or replacement expenses
- The service of blood donors, including yourself, apheresis or plasmapheresis
- The blood you donate for your own use, excluding administration and processing expenses and except where described in the *Coverage and exclusion*s, *Transplant services* section

This exception does not include services or supplies to treat hemophilia or other congenital bleeding disorders.

Cosmetic services and plastic surgery

Any treatment, **surgery** (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body, whether or not for psychological or emotional reasons, except where described in *Coverage and exclusions* under the *Reconstructive breast surgery and supplies* and *Reconstructive surgery and supplies* sections

Cost share waived

Any cost for a service when any **out-of-network provider** waives all or part of your **copayment**, **coinsurance**, **deductible**, or any other amount

Counseling

Marriage, religious, family, career, social adjustment, pastoral or financial counseling

Court-ordered services and supplies

Includes court-ordered services and supplies, or those required as a condition of parole, probation, release or because of any legal proceeding

Custodial care

Services and supplies meant to help you with activities of daily living or other personal needs.
Examples of these are:

- Routine patient care such as changing dressings, periodic turning and positioning in bed
- Administering oral medications
- Care of stable tracheostomy (including intermittent suctioning)
- Care of a stable colostomy/ileostomy
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings
- Care of a bladder catheter, including emptying or changing containers and clamping tubing
- Watching or protecting you
- Respite care, adult or child day care, or convalescent care
- Institutional care, including **room and board** for rest cures, adult day care and convalescent care

- Help with walking, grooming, bathing, dressing, getting in or out of bed, going to the bathroom, eating or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform

Educational services

Examples of these are:

- Any service or supply for education, training or retraining services or testing, except as described in the *Coverage and exclusions* section. This includes:
  - Special education
  - Remedial education
  - Wilderness treatment programs (whether or not the program is part of a **residential treatment facility** or otherwise licensed institution)
  - Job training
  - Job hardening programs
- Educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

Examinations

Any health or dental examinations needed:

- Because a third party requires the exam. Examples include examinations to get or keep a job, and examinations required under a labor agreement or other contract.
- To buy insurance or to get or keep a license.
- To travel.
- To go to a school, camp, sporting event, or to join in a sport or other recreational activity.

Experimental or investigational

Experimental or investigational drugs, devices, treatments or procedures unless otherwise covered under clinical trials.

Foot care

Non-diabetic services and supplies for the following:

- The treatment of calluses, bunions, toenails, hammertoes or fallen arches
- The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes
- Supplies (including orthopedic shoes), ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies

Foot orthotic devices

Foot orthotics or other devices to support the feet, such as arch supports and shoe inserts, unless required for the treatment of or to prevent complications of diabetes

Growth/height care

- A treatment, device, drug, service or supply to increase or decrease height or alter the rate of growth

- **Surgical procedures**, devices and growth hormones to stimulate growth

Hearing aids

- Any tests, appliances and devices to:
  - Improve your hearing
  - Enhance other forms of communication to make up for hearing loss or devices that simulate speech

Maintenance care

Care made up of services and supplies that maintain, rather than improve, a level of physical or mental function, except for habilitation therapy services

Medical supplies – outpatient disposable

- Any outpatient disposable supply or device. Examples of these include:
  - Sheaths
  - Bags
  - Elastic garments
  - Support hose
  - Bandages
  - Bedpans
  - Home test kits not related to diabetic testing
  - Splints
  - Neck braces
  - Compresses
  - Other devices not intended for reuse by another patient

Mental health treatment

Services for the following categories (or equivalent terms as listed in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association):

- **Stay** in a facility for treatment for dementia and amnesia without a behavioral disturbance that necessitates mental health treatment
- Sexual deviations and disorders except for gender identity disorders
- Tobacco use disorders, except as described in the *Coverage and exclusions – Preventive care* section
- Pathological gambling, kleptomania, pyromania
- School and/or education service, including special education, remedial education, wilderness treatment programs, or any such related or similar programs
- Services provided in conjunction with school, vocation, work or recreational activities
- Transportation

Missed appointments

Any cost resulting from a canceled or missed appointment

Obesity surgery and services

Weight management treatment or drugs intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity except as described in the *Coverage and exclusions* section,

including preventive services for obesity screening and weight management interventions. This is regardless of the existence of other medical conditions. Examples of these are:

- Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric **surgery**
- **Surgical procedures**, medical treatments and weight control/loss programs primarily intended to treat, or are related to the treatment of obesity, including morbid obesity
- Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications
- Hypnosis, or other forms of therapy
- Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement

Other non-covered services

- Services you have no legal obligation to pay
- Services that would not otherwise be charged if you did not have the coverage under the plan

Other primary payer

Payment for a portion of the charges that Medicare or another party is responsible for as the primary payer

Personal care, comfort or convenience items

Any service or supply primarily for your convenience and personal comfort or that of a third party

Private duty nursing

Services provided by a family member

Services provided by a spouse, domestic partner, parent, child, step-child, brother, sister, in-law, or any household member

Services, supplies and drugs received outside of the United States

Non-emergency medical services, outpatient **prescription** drugs or supplies received outside of the United States. They are not covered even if they are covered in the United States under this certificate.

Sexual dysfunction and enhancement

Any treatment, **prescription** drug, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:

- **Surgery**, **prescription** drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity or alter the shape of a sex organ
- Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services

Strength and performance

Services, devices and supplies such as drugs or preparations designed primarily to enhance your strength, physical condition, endurance or physical performance

Telemedicine

- Services given when you are not present at the same time as the **provider**
- Audio only telephone calls
- **Telemedicine** kiosks

Therapies and tests

- Full body CT scans that are not **medically necessary**
- Hair analysis
- Hypnosis and hypnotherapy
- Massage therapy, except when used for physical therapy treatment
- Sensory or hearing and sound integration therapy

Treatment in a federal, state, or governmental entity

Any care in a **hospital** or other facility owned or operated by any federal, state or other governmental entity unless coverage is required by applicable laws

Voluntary sterilization

- Reversal of voluntary sterilization procedures, including related follow-up care

Wilderness treatment programs

See *Educational services* in this section

Work related illness or injuries

Coverage available to you under workers' compensation or a similar program under local, state or federal law for any illness or injury related to employment or self-employment

Important note:
A source of coverage or reimbursement is considered available to you even if you waived your right to payment from that source. You may also be covered under a workers' compensation law or similar law. If you submit proof that you are not covered for a particular illness or injury under such law, then that illness or injury will be considered "non-occupational" regardless of cause.

How your plan works

How your plan works while you are covered in-network

Your in-network coverage:

- Helps you get and pay for a lot of – but not all – health care services
- Generally pays only when you get care from **network providers**

Your cost share is lower when you use a **network provider**.

Providers

Our **provider** network is there to give you the care you need. You can find **network providers** and see important information about them most easily on our online **provider** directory. Just log into the Innovation Health website. Or call the toll-free number on your member ID card to request a printed directory.

You may choose a **PCP** to oversee your care. Your **PCP** will provide routine care and send you to other **providers** when you need specialized care. You don't have to get care through your **PCP**. You may go directly to **network providers**. Your plan often will pay a bigger share for **covered services** you get through your **PCP**, so choose a **PCP** as soon as you can.

For more information about the network and the role of your **PCP**, see the *Who provides the care* section.

Service area

Your plan generally pays for **covered services** only within a specific geographic area, called a service area. There are some exceptions, such as for **emergency services**, urgent care, and transplants. See the *Who provides the care* section below.

How your plan works while you are covered out-of-network

With your out-of-network coverage:

- You can get care from **providers** who are not part of the Innovation Health network
- You may have to pay the full cost for your care, and then submit a claim to be reimbursed
- You are responsible to get any required **precertification**
- Your cost share will be higher

Who provides the care

Network providers

We have contracted with **providers** in the service area to provide **covered services** to you. These **providers** make up the network for your plan.

To get network benefits, you must use **network providers**. There are some exceptions:

- **Emergency services** – see the description of **emergency services** in the *Coverage and exclusions* section.
- Urgent care – see the description of urgent care in the *Coverage and exclusions* section.

- **Network provider** not reasonably available – You can get services from an **out-of-network provider** if an appropriate **network provider** is not reasonably available. You must request approval from us before you get the care. Contact us for assistance.
- Transplants – see the description of transplant services in the *Coverage and exclusions* section.

You may select a **network provider** from the online directory through the Innovation Health website.

You will not have to submit claims for services received from **network providers**. Your **network provider** will take care of that for you. And we will pay the **network provider** directly for what the plan owes.

Your PCP

We encourage you to get **covered services** through a **PCP**. They will provide you with primary care.

How you choose your PCP

You can choose a **PCP** from the list of **PCP**s in our directory.

Each covered family member is encouraged to select a **PCP**. You may each choose a different **PCP**. You should select a **PCP** for your covered dependent if they are a minor or cannot choose a **PCP** on their own.

What your PCP will do for you

Your **PCP** will coordinate your medical care or may provide treatment. They may send you to other **network providers**.

Changing your PCP

You may change your **PCP** at any time by contacting us.

Out-of-network providers

You can also get care from **out-of-network providers**. When you use an **out-of-network provider**, your cost share is higher. You are responsible for:

- Your out-of-network **deductible**
- Your out-of-network **coinsurance**
- Any charges over the **allowable amount**
- Submitting your own claims and getting **precertification**

Keeping a provider you go to now (continuity of care)

You may have to find a new **provider** when:

- You join the plan and the **provider** you have now is not in the network
- You are already an Innovation Health member and your **provider** stops being in our network

However, in some cases, you may be able to keep going to your current **provider** to complete a treatment or to have treatment that was already scheduled. This is called continuity of care. This includes treatment for disability, and life-threatening and **terminal illness**.

Care will continue during a transitional period, at least 90 days if you are in an active course of treatment, but this may vary based on your condition.

If this situation applies to you, contact us for details. If we approve your request to keep going to your current **provider**, we will tell you how long you can continue to see the **provider**. If you are pregnant and have entered your second trimester, this will include the time required for postpartum care directly related to the delivery. If you are terminally ill, the transitional period is the remainder of your life for care directly related to treatment of the **terminal illness**.

For a transitional 90-day period after the date a **provider** stops participating in our network, we will authorize coverage for the 90-day period in accordance with our agreement with the **provider** existing immediately before the **provider** stops participating. The transitional period does not apply if the **provider** has been terminated for cause.

For the transitional period for a **provider** that is not in our network, we will authorize coverage for the transitional period only if the **provider** agrees to our usual terms and conditions for contracting **providers**.

Medical necessity and precertification requirements

Your plan pays for its share of the expense for **covered services** only if the general requirements are met. They are:

- The service is **medically necessary**
- For in-network benefits, you get the service from a **network provider**
- Your **provider precertifies** the service when required. This includes determining that services are not more costly than an alternative service or sequence of services or site of service at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

Medically necessary, medical necessity

The **medical necessity** requirements are in the *Glossary* section, where we define "**medically necessary**, **medical necessity**." That is where we also explain what our medical directors or a **physician** they assign consider when determining if a service is **medically necessary**.

Important note:
We cover **medically necessary**, sex-specific **covered services** regardless of identified gender.

Our clinical policy bulletins explain our policy for specific services and supplies. We use these bulletins and other resources to help guide individualized coverage decisions under our plans. You can find the bulletins and other information at https://www.innovationhealth.com.

Precertification

You need pre-approval from us for some **covered services**. Pre-approval is also called **precertification**.

In-network

Your network **physician** or **PCP** is responsible for obtaining any necessary **precertification** before you get the care. **Network providers** cannot bill you if they fail to ask us for **precertification**.

Out-of-network
When you go to an **out-of-network provider**, you are responsible to get any required **precertification** from us. If you don't **precertify**:

- Your benefits may be reduced, or the plan may not pay. See your schedule of benefits for details.
- You will be responsible for the unpaid bills.
- Your additional out-of-pocket expenses will not count toward your **deductible** or **maximum out-of-pocket limit**.

Timeframes for **precertification** are listed below. For **emergency services**, **precertification** is not required, but you should notify us as shown.

To obtain **precertification**, contact us. You, your **physician** or the facility must call us within these timelines:

Type of care	Timeframe
Non-emergency admission	Call at least 14 days before the date you are scheduled to be admitted.
Emergency admission	Call within 48 hours or as soon as reasonably possible after you have been admitted.
Urgent admission	Call before you are scheduled to be admitted.
Outpatient non-emergency medical services	Call at least 14 days before the care is provided, or the treatment or procedure is scheduled.

An urgent admission is a **hospital** admission by a **physician** due to the onset of or change in an illness, the diagnosis of an illness, or injury.

We will tell you and your **physician** in writing of the **precertification** decision, where required by state law. An approval is valid for 180 days as long as you remain enrolled in the plan.

For an inpatient **stay** in a facility, we will tell you, your **physician** and the facility about your **precertified** length of **stay**. If your **physician** recommends that you stay longer, the extra days will need to be **precertified**. You, your **physician**, or the facility will need to call us as soon as reasonably possible, but no later than the final authorized day. We will tell you and your **physician** in writing of an approval or denial of the extra days.

If you or your **provider** request **precertification** and we don't approve coverage, we will tell you why and explain how you or your **provider** may request review of our decision. See the *Complaints, claim decisions and appeal procedures* section.

Types of services that require precertification
Precertification is required for inpatient **stays** (such as hospital, hospice, skilled nursing/rehabilitation/residential treatment facilities) and certain outpatient services and supplies (such as complex imaging, sleep studies, transcranial magnetic stimulation (TMS), psychological testing, and applied behavior analysis). These examples are only a few of many services that require precertification.

Visit our website at https://www.innovationhealth.com or contact us to get a list of the services that require **precertification**. The list may change from time to time.

Sometimes you or your **provider** may want us to review a service that doesn't require **precertification** before you get care. This is called a predetermination, and it is different from **precertification**. Predetermination means that you or your **provider** requests the pre-service clinical review of a service that does not require **precertification**.

Certain **prescription** drugs are covered under the medical plan when they are given to you by your doctor or health care facility. The following **precertification** information applies to these **prescription** drugs:

For certain drugs, your **provider** needs to get approval from us before we will cover the drug. The requirement for getting approval in advance guides appropriate use of certain drugs and makes sure they are **medically necessary**.

Off-label prescription drugs

FDA approved prescription drugs may be covered when the off-label use of the drug has not been approved by the FDA for your symptom(s). Eligibility for coverage is subject to the following:

- The drug has been approved by the FDA for at least one indication and the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.
- The drug is prescribed for the treatment of cancer and it is recognized as safe and effective for treatment of that specific type of cancer in any of the standard reference compendium even if the drug is not approved by the FDA for a particular indication.
- The drug is approved by the FDA for use in the treatment of cancer pain and the dosage is in excess of the recommended dosage for a patient with intractable cancer pain.

Step therapy is a type of **precertification** where we require you to first try certain drugs to treat your medical condition before we will cover another drug for that condition.

Contact us or go online to get the most up-to-date **precertification** requirements and list of **step therapy** drugs.

Sometimes you or your **provider** may ask for a medical exception for drugs that are not covered or for which coverage was denied . You, someone who represents you or your **provider** can contact us. You will need to provide us with clinical documentation. After we receive your request and any information, we will:

- Review and act upon your request within one business day
- Tell you and your **provider** of our coverage determination within 72 hours

Any exception granted is based upon an individual and is a case-by-case decision that will not apply to other members.

If approved by us, you will receive the exception for the entire time of the **prescription**. See the *Prescription drug plan rider* for additional information.

If we deny your request for a medical exception, including **step therapy,** you have the right to request an external review by an Independent Review Organization (IRO). The IRO will tell you and your **provider** of the coverage decision no later than 72 hours (including hours on weekends) after we receive your request. For urgent situations, we will tell you or your **provider** of the coverage decision no later than 24 hours (including hours on weekends) after we receive your request. If the IRO approves your request, coverage will be provided for the entire time you have an urgent situation. If the IRO denies your request, you have the right to appeal the decision.

What the plan pays and what you pay

Who pays for your **covered services** – this plan, both of us, or just you? That depends.

The general rule

The schedule of benefits lists what you pay for each type of **covered service**. In general, this is how your benefit works:

- You pay the **deductible**, when it applies.
- Then the plan and you share the expense. Your share is called a **copayment** or **coinsurance**.
- Then the plan pays the entire expense after you reach your **maximum out-of-pocket limit**.

When we say "expense" in this general rule, we mean the **negotiated charge** for a **network provider**, and **allowable amount** for an **out-of-network provider**.

Negotiated charge

For health coverage:
This is the amount a **network provider** has agreed to accept or that we have agreed to pay them or a third party vendor.

We may enter into arrangements with **network providers** or others related to:

- The coordination of care for members
- Improving clinical outcomes and efficiencies

Some of these arrangements are called:

- Value-based contracting
- Risk sharing
- Accountable care arrangements

These arrangements will not change the **negotiated charge** under this plan.

*For **prescription** drug services:*
When you get a **prescription** drug, we have agreed to this amount for the **prescription** or paid this amount to the **network pharmacy** or third-party vendor that provided it. The **negotiated charge** may include a rebate, additional service or risk charges and administrative fees. It may include additional amounts paid to or received from third parties under price guarantees.

Allowable amount

This is the amount of an **out-of-network provider's** charge that is eligible for coverage. You are responsible for all charges above this amount. The **allowable amount** depends on the geographic area

where you get the service or supply. **Allowable amount** doesn't apply to involuntary services. These are services or supplies that are:

- Provided at a network facility by an **out-of-network provider**
- Not available from a **network provider**
- An **emergency service**

The table below shows the method for calculating the **allowable amount** for specific services or supplies.

Service or supply:	**Allowable amount is based on:**
Professional services and other services or supplies not mentioned below	105% of the Medicare Allowable Rate
Services of **hospitals** and other facilities	140% of the Medicare Rate

Important note:
See Special terms used, below, for a description of what the **allowable amount** is based on.
If the **provider** bills less than the amount calculated using a method above, the **allowable amount** is what the **provider** bills

If your ID card displays the National Advantage Program (NAP) logo, your cost share may be lower when you get care from a NAP **provider**. These are **out-of-network providers** and third party vendors who have contracts with us but are not **network providers**. When you get care from a NAP **provider**, your **out-of-network** cost share applies.

Special terms used:

- Geographic area is normally based using the first three digits of a zip code. If we believe we need more data for a particular service or supply, we may base rates on a wider geographic area such as the entire state.
- Medicare allowed rates are the rates CMS establishes for services and supplies provided to Medicare enrollees without taking into account adjustments for specific **provider** performance. We update our system with these when revised within 180 days of receiving them from CMS. If Medicare doesn't have a rate, we use one or more of the items below to determine the rate for a service or supply:
  - The method CMS uses to set Medicare rates
  - How much other **providers** charge or accept as payment
  - How much work it takes to perform a service
  - Other things as needed to decide what rate is reasonable

Our reimbursement policies
We have the right to apply our reimbursement policies to all out-of-network services including involuntary services. This may affect the **allowable amount**. When we do this, we consider:

- The length and difficulty of a service
- Whether additional expenses are needed, when multiple procedures are billed at the same time
- Whether an assistant surgeon is needed
- If follow up care is included
- Whether other conditions change or make a service unique

- Whether any of the services described by a claim line are part of or related to the primary service provided, when a charge includes more than one claim line
- The educational level, licensure or length of training of the **provider**

We base our reimbursement policies on our review of:
- CMS National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and aren't appropriate
- Generally accepted standards of medical and dental practice
- The views of **physicians** and dentists practicing in relevant clinical areas

We use commercial software to administer some of these policies. Policies may differ for professional services and facility services.

Get the most from your benefits:
We have online tools to help you decide whether to get care and if so, where. Use the 'Estimate the Cost of Care' tool on the Innovation Health website. With this feature, you can view other tools like our 'Cost of Care' and 'Member Payment Estimator'.

Paying for covered services – the general requirements

There are several general requirements for the plan to pay any part of the expense for a **covered service**. For in-network coverage, they are:
- The service is **medically necessary**
- You get your care from a **network provider**
- You or your **provider** precertifies the service when required

For out-of-network coverage:
- The service is **medically necessary**
- You get your care from an **out-of-network provider**
- You or your **provider** precertifies the service when required

Generally, your plan and you share the cost for **covered services** when you meet the general requirements. But sometimes your plan will pay the entire expense, and sometimes you will. For details, see your schedule of benefits and the information below.

You pay the entire expense when:
- You get services or supplies that are not **medically necessary**.
- You get care from an **out of-network provider** and the **provider** waives all or part of your cost share

You may pay the entire expense when:
- Your plan requires **precertification**, your **physician** or **PCP** requests **precertification,** and after receiving a denial in writing, you still choose to get the care. See the *Complaints, claim decisions and appeal procedures* and *Precertification* sections for more information.

In all these cases, the **provider** may require you to pay the entire charge. Any amount you pay will not count towards your **deductible** or your **maximum out-of-pocket limit**.

Where your schedule of benefits fits in

The schedule of benefits shows any out-of-pocket costs you are responsible for when you receive **covered services** and any benefit limitations that apply to your plan. It also shows any **maximum out-of-pocket limits** that apply. We will notify you that you have met your **maximum out-of-pocket** no later than 30 days after we have paid enough claims to make that determination. You will not be required to pay cost share for eligible **covered services** for the rest of the plan year. Any amounts over your **maximum out-of-pocket** will be promptly refunded to you.

Limitations include things like maximum age, visits, days, hours and admissions. Out-of-pocket costs include things like **deductibles**, **copayments** and **coinsurance**.

Keep in mind that you are responsible for paying your part of the cost sharing. You are also responsible for costs not covered under this plan.

Coordination of benefits

Some people have health coverage under more than one health plan. If you do, we will work with your other plan to decide how much each plan pays. This is called coordination of benefits (COB).

Key Terms

Here are some key terms we use in this section. These will help you understand this COB section.

Allowable expense means a health care expense that any of your health plans cover.

In this section when we talk about "plan" through which you may have other coverage for health care expenses we mean:

- Group or non-group, blanket, or franchise health insurance policies issued by insurers, HMOs, or health care service contractors
- Health insurance policies provided by labor-management trustee plans, labor organization plans, employer organization plans, or employee benefit organization plans
- Medicare or other government benefits
- Any health insurance policy or contract that you maintain only because of membership in or connection with a particular organization or group

How COB works

- When this is your primary plan, we pay your medical claims first as if there is no other coverage.
- When this is your secondary plan:
  - We pay benefits after the primary plan and coordinate our payment based on any amount the primary plan paid.
  - Total payments from this plan and your other coverage will never add up to more than 100% of the allowable expenses.
  - Each family member has a separate benefit reserve for each year. The benefit reserve balance is:
    - The amount that the secondary plan saved due to COB
    - Used to cover any unpaid allowable expenses
    - Erased at the end of the year

Determining who pays

The basic rules are listed below. Reading from top to bottom the first rule that applies will determine which plan is primary and which is secondary. Contact us if you have questions or want more information.

A plan that does not contain a COB provision is always the primary plan.

COB rule	Primary Plan	Secondary plan
Non-dependent or dependent	Plan covering you as an employee, retired employee or subscriber (not as a dependent)	Plan covering you as a dependent
Child – parents married or living together	Plan of parent whose birthday (month and day) is earlier in the year (Birthday rule)	Plan of parent whose birthday is later in the year
Child – parents separated, divorced, or not living together	• Plan of parent responsible for health coverage in court order • Birthday rule applies if both parents are responsible or have joint custody in court order • Custodial parent's plan if there is no court order	• Plan of other parent • Birthday rule applies (later in the year) • Non-custodial parent's plan
Child – covered by individuals who are not parents (i.e. stepparent or grandparent)	Same rule as parent	Same rule as parent
Active or inactive employee	Plan covering you as an active employee (or dependent of an active employee)	Plan covering you as a laid off or retired employee (or dependent of a former employee)
Consolidated Omnibus Budget Reconciliation Act (COBRA) or state continuation	Plan covering you as an employee or retiree (or dependent of an employee or retiree)	COBRA or state continuation coverage
Longer or shorter length of coverage	Plan that has covered you longer	Plan that has covered you for a shorter period of time
Other rules do not apply	Plans share expenses equally	Plans share expenses equally

How COB works with Medicare

If your other coverage is under Medicare, federal laws explain whether Medicare will pay first or second. COB with Medicare will always follow federal requirements. Contact us if you have any questions about this.

When you are eligible for Medicare, we coordinate the benefits we pay with the benefits that Medicare pays. If you are eligible due to age but not covered, we may still pay as if you are covered by Medicare and coordinate with the benefits Medicare would have paid. Sometimes, this plan pays benefits before

Medicare pays. Sometimes, this plan pays benefits after Medicare or after an amount that Medicare would have paid if you had been covered.

You are eligible for Medicare if you are covered under it. You are also eligible for Medicare even if you are not covered if you refused it, dropped it, or didn't make a request for it.

Other health coverage updates – contact information

You should contact us if you have any changes to your other coverage. We want to be sure our records are accurate so your claims are processed correctly.

Our rights

We have the right to:

- Release or obtain any information we need for COB purposes, including information we need to recover any payments from your other health plans
- Reimburse another health plan that paid a benefit we should have paid
- Recover any excess payment from a person or another health plan, if we paid more than we should have paid

Benefit payments and claims

A claim is a request for payment that you or your health care **provider** submits to us when you want or get **covered services**. There are different types of claims. You or your **provider** may contact us at various times, to make a claim, to request approval, or payment, for your benefits. This can be before you receive your benefit, while you are receiving benefits and after you have received the benefit.

It is important that you carefully read the previous sections within *How your plan works*. When a claim comes in, we review it, make a decision and tell you how you and we will split the expense. The amount of time we have to tell you about our decision on a claim depends on the type of claim.

Claim type and timeframes

Urgent care claim

An urgent claim is one for which the doctor treating you decides a delay in getting medical care could put your life or health at risk. Or a delay might put your ability to regain maximum function at risk. It could also be a situation in which you need care to avoid severe pain. We will make a decision within 72 hours.

If you are pregnant, an urgent claim also includes a situation that can cause serious risk to the health of your unborn baby.

Pre-service claim

A pre-service claim is a claim that involves services you have not yet received and which we will pay for only if we **precertify** them. We will make a decision within 15 days.

Post-service claim

A post-service claim is a claim that involves health care services you have already received. We will make a decision within 30 days.

Concurrent care claim extension
A concurrent care claim extension occurs when you need us to approve more services than we already have approved. Examples are extending a **hospital stay** or adding a number of visits to a **provide**r. You must let us know you need this extension 24 hours before the original approval ends. We will have a decision within 24 hours for an urgent request. You may receive the decision for a non-urgent request within 15 days.

Concurrent care claim reduction or termination
A concurrent care claim reduction or termination occur when we decide to reduce or stop payment for an already approved course of treatment. We will notify you of such a determination. You will have enough time to file an appeal. Your coverage for the service or supply will continue until you receive a final appeal decision from us or an external review organization if the situation is eligible for external review.

During this continuation period, you are still responsible for your share of the costs, such as **copayments**, **coinsurance** and **deductibles** that apply to the service or supply. If we uphold our decision at the final internal appeal, you will be responsible for all of the expenses for the service or supply received during the continuation period.

Filing a claim

When you see a **network provider**, that office will usually send us a detailed bill for your services. If you see an **out-of-network provider**, you may receive the bill (proof of loss) directly. This bill forms the basis of your post-service claim. If you receive the bill directly, you should send it to us as soon as possible with a claim form that you can either get online or contact us to provide. You should always keep your own record of the date, **providers** and cost of your services.

The benefit payment determination is made based on many things, such as your **deductible** or **coinsurance**, the **medical necessity** of the service you received, or when or where you receive the services. We may need to ask you or your **provider** for some more information to make a final decision. You can always contact us directly to see how much you can expect to pay for any service.
We will pay the claim within 30 days from when we receive all the information necessary. Sometimes we may pay only some of the claim. Sometimes we may deny payment entirely. We may even rescind your coverage entirely.

We will pay the claim within 30 days from when we receive all the information necessary. Sometimes we may pay only some of the claim. Sometimes we may deny payment entirely. We may even rescind your coverage entirely.

We will give you our decision in writing. You may not agree with our decision. There are several ways to have us review the decisions. Please see the *Complaints, claim decisions and appeal procedures* section for that information.

Complaints, claim decisions and appeal procedures

The difference between a complaint and an appeal

Complaint

You may not be happy about a **provider** or an operational issue, and you may want to complain. You can contact us at any time. This is a complaint. Your complaint should include a description of the issue. You should include copies of any records or documents you think are important. We will review the information and give you a written response within 30 calendar days of receiving the complaint. We will let you know if we need more information to make a decision.

Appeal

When we make a decision to deny services or reduce the amount of money we pay on your care or out-of-pocket expense, it is an adverse benefit determination. You can ask us to re-review that determination. This is an appeal. You can start an appeal process by contacting us.

Claim decisions and appeal procedures

Your **provider** may contact us at various times to make a claim, or to request approval for payment based on your benefits. This can be before you receive your benefit, while you are receiving benefits and after you have received the benefit. You may not agree with our decision. As we said in *Benefit payments and claims* in the *How your plan works* section, we pay many claims at the full rate, except for your share of the costs. But sometimes we pay only some of the claim. Sometimes we deny payment entirely.

Any time we deny even part of the claim, it is an "adverse benefit determination" or "adverse decision." For any adverse decision, you will receive an explanation of benefits in writing. You can ask us to review an adverse benefit determination. This is the internal appeal process. If you still don't agree, you can also appeal that decision. There are times you may skip the two levels of internal appeal. But in most situations you must complete both levels before you can take any other actions, such as an external review.

Appeal of an adverse benefit determination

Urgent care or pre-service claim appeal

If your claim is an urgent claim or a pre-service claim, your **provider** may appeal for you without having to fill out an appeal form. We will give you an answer within 36 hours for an urgent appeal and within 15 days for a pre-service appeal. A concurrent claim appeal will be addressed according to what type of service and claim it involves.

Any other claim appeal

You must file an appeal within 180 calendar days from the time you receive the notice of an adverse benefit determination.

You can appeal by sending a written appeal to the address on the notice of adverse benefit determination, or by contacting us. You need to include:

- Your name
- The contract holder's name

- A copy of the adverse benefit determination
- Your reasons for making the appeal
- Any other information you would like us to consider

We will assign your appeal to someone who was not involved in making the original decision. You will receive a decision within 30 days for a post-service claim.

If you are still not satisfied with the answer, you may make a second internal appeal. You must present your appeal within 60 calendar days from the date you receive the notice of the first appeal decision.

Another person may submit an appeal for you, including a **provider**. That person is called an authorized representative. You need to tell us if you choose to have someone else appeal for you (even if it is your **provider**). You should fill out an authorized representative form telling us you are allowing someone to appeal for you. You can get this form on our website or by contacting us. The form will tell you where to send it to us. You can use an authorized representative at any level of appeal.

At your last available level of appeal, we will give you any new or additional information we may find and use to review your claim. There is no cost to you. We will give you the information before we give you our decision. This decision is called the final adverse benefit determination. You can respond to the information before we tell you what our final decision is.

Prescription drug exception request

See the *Medical necessity and precertification requirements* section for the process to submit an exception request for **prescription** drugs that are not covered under this policy.

Exhaustion of appeal process

In most situations, you must complete the two levels of appeal with us before you can take these other actions:

- Appeal through an external review process
- Pursue litigation or other type of administrative proceeding

Sometimes you do not have to complete the two levels of appeal before you may take other actions. These situations are:

- You have an urgent claim or claim that involves ongoing treatment or a claim that involves treatment of cancer. You can have your claim reviewed internally and through the external review process at the same time.
- You will not be able to proceed directly to external review if:
  - The rule violation was minor and not likely to influence a decision or harm you
  - The violation was for a good cause or beyond our control
  - The violation was part of an ongoing, good faith exchange between you and us

External review

External review is a review done by people in an organization outside of Innovation Health. This is called an independent review organization (IRO).

You have a right to external review only if all the following conditions are met:

- You have received an adverse benefit determination
- Our claim decision involved medical judgement
- We decided the service or supply is not **medically necessary**, not appropriate, or we decided the service or supply is **experimental or investigational**

If our claim decision is one for which you can seek external review, we will say that in the notice of adverse benefit determination or final adverse benefit determination we send you. That notice also will describe the external review process. It will include a copy of the request for external review form at the final adverse determination level.

You must submit the request for external review form:

- To Virginia Bureau of Insurance
- Within 120 calendar days of the date you received the final adverse decision from us

You will pay for any information that you send and want reviewed by the IRO. We will pay for information we send to the IRO plus the cost of the review.

The Virginia Bureau of Insurance will:

- Contact the IRO that will conduct the review of your claim

The IRO will:

- Assign the appeal to one or more independent clinical reviewers that have proper expertise to do the review
- Consider appropriate credible information that you sent
- Follow our contractual documents and your plan of benefits
- Send notification of the decision within 45 calendar days of the date we receive your request form and all the necessary information

We will stand by the decision that the IRO makes.

How long will it take to get an IRO decision?

We will give you the IRO decision not more than 45 calendar days after we receive your notice of external review form with all the information you need to send in.

Sometimes you can get a faster external review decision. You or your **provider** must submit a request for external review form to the Virginia Bureau of Insurance.

There are two scenarios when you may be able to get a faster external review:

For initial adverse benefit determinations

- Your treatment is for cancer or your **provider** tells the Virginia Bureau of Insurance that a delay in receiving health care services would:
  - Jeopardize your life, health or ability to regain maximum function
  - Be much less effective if not started right away (in the case of **experimental or investigational** treatment)

For final adverse determinations

- Your treatment is for cancer or your **provider** tells the Virginia Bureau of Insurance that a delay in receiving health care services would:
- Jeopardize your life, health or ability to regain maximum function
- Be much less effective if not started right away (in the case of **experimental or investigational** treatment), or
- The final adverse determination concerns an admission, availability of care, continued **stay** or health care service for which you received **emergency services**, but have not been discharged from a facility

If your situation qualifies for this faster review, you will receive a decision within 72 hours of the IRO's receipt of the request.

Managed care ombudsman

If you have any questions regarding an appeal which have not been satisfactorily addressed by us, you may contact the Virginia Office of the Managed Care Ombudsman for assistance.

Virginia Office of the Managed Care Ombudsman
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218

Toll-free: (877) 310-6560
Richmond Metropolitan Area: (804) 371-9032
E-mail: ombudsman@scc.virginia.gov

Virginia department of health, office of licensure and certification

You or your **provider** can contact the Office of Licensure and Certification to file a complaint regarding quality of care, choice and accessibility of **providers** or network adequacy. The contact information is shown below.

Virginia Department of Health
Office of Licensure and Certification
9960 Mayland Drive, Suite 401
Richmond, Virginia 23233-1463

Toll-free: 1-800-955-1819
Richmond Metropolitan Area: (804) 367-2104
E-mail: OLC-Complaints@vdh.virginia.gov
Fax: (804) 527-4503

Recordkeeping

We will keep the records of all complaints and appeals for at least 10 years.

Fees and expenses

We do not pay any fees or expenses incurred by you in pursuing a complaint or appeal.

Eligibility, starting and stopping coverage

Eligibility

Who is eligible

The contract holder decides and tells us who is eligible for health coverage.

When you can join the plan

You must live or work in the service area to enroll in this plan.

You can enroll:

- At the end of any waiting period the contract holder requires
- Once each year during the annual enrollment period
- At other special times during the year (see the *Special times you can join the plan* section below)

You can enroll eligible family members (these are your "dependents") at this time too.
If you don't enroll when you first qualify for benefits, you may have to wait until the next annual enrollment period to join.

Who can be a dependent on this plan

You can enroll the following family members:

- Your legal spouse
- Your domestic partner who meets contract holder rules and requirements under state law
- Dependent children – yours or your spouse's or partner's
    - Dependent children must be:
        - Under 26 years of age
    - Dependent children include:
        - Natural children
        - Stepchildren
        - Adopted children including those placed with you for adoption
        - Foster children
        - Children you are responsible for under a qualified medical support order or court order

Adding new dependents

You can add new dependents during the year. These include any dependents described in the *Who can be a dependent on this plan* section above.

Coverage begins on the date of the event for new dependents who join your plan for the following reasons:

- Birth
- Adoption or placement for adoption
- Marriage
- Legal guardianship
- Court or administrative order

We must receive a completed enrollment form not more than 31 days after the event date.

Special times you can join the plan

You can enroll in these situations:

- You didn't enroll before because you had other coverage and that coverage has ended
- Your COBRA coverage has ended
- A court orders that you cover a dependent on your health plan

We must receive the completed enrollment information within 31 days after the event date.

You can also enroll in these situations:

- You or your dependent lose your eligibility for enrollment in Medicaid or an S-CHIP plan
- You are now eligible for state premium assistance under Medicaid or S-CHIP which will pay your premium contribution under this plan

We must receive the completed enrollment information within 60 days of the event date.

Notification of change in status

Tell us of any changes that may affect your benefits. Please contact us as soon as possible when you have a:

- Change of address
- Dependent status change
- Dependent who enrolls in Medicare or any other health plan

Starting coverage

Your coverage under this plan has a start and an end. You must start coverage after you complete the eligibility and enrollment process. You can ask your contract holder to confirm your effective date.

Stopping coverage

Your coverage typically ends when you leave your job; but it can happen for other reasons. Ending coverage doesn't always mean you lose coverage with us. There will be circumstances that will still allow you to continue coverage. See the *Special coverage options after your coverage ends* section.

We will give you 31 days advance written notice if your coverage is ending. This notice will tell you the date that your coverage ends.

Your coverage under this plan will end if:

- This plan is no longer available
- You ask to end coverage
- The contract holder asks to end coverage
- You are no longer eligible for coverage, including when you move out of the service area
- Your work ends
- You stop making required contributions, if any apply
- We end your coverage
- You start coverage under another medical plan offered by your employer

When dependent coverage ends

Dependent coverage will end if:

- A dependent is no longer eligible for coverage
- You stop making premium contributions, if any apply
- Your coverage ends for any of the reasons listed above except:
  - Exhaustion of your overall maximum benefit.
  - You enroll under a group Medicare plan we offer. However, dependent coverage will end if your coverage ends under the Medicare plan.
- The date this plan no longer allows coverage for domestic partners
- The date the domestic partnership ends
  - You will need to complete a Declaration of Termination of Domestic Partnership

What happens to your dependents if you die?

Coverage for dependents may continue for some time after your death. See the *Special coverage options after your coverage ends* section for more information.

When dependent coverage ends

Dependent coverage will end if:

- A dependent is no longer eligible for coverage
- You stop making premium contributions, if any apply
- Your coverage ends for any of the reasons listed above except:
  - Exhaustion of your overall maximum benefit.
  - You enroll under a group Medicare plan we offer. However, dependent coverage will end if your coverage ends under the Medicare plan.

What happens to your dependents if you die?

Coverage for dependents may continue for some time after your death. See the *Special coverage options after your coverage ends* section for more information.

Why would we end your coverage?

We will give you 31 days advance written notice if we end your coverage because you commit fraud or you intentionally misrepresented yourself when you applied for or obtained coverage. You can refer to the *General provisions – other things you should know* section for more information on rescissions.

On the date your coverage ends, we will refund to your employer any prepayment for periods after the date your coverage ended.

Special coverage options after your coverage ends

When coverage may continue under the plan

This section explains options you may have after your coverage ends under this plan. Your individual situation will determine what options you will have. Contact the contract holder to see what options apply to you.

In some cases, premium payment is required for coverage to continue. Your coverage will continue under the plan as long as the contract holder and we have agreed to do so. It is the contract holder's responsibility to let us know when your work ends. If the contract holder and we agree in writing, we will extend the limits.

Consolidated Omnibus Budget Reconciliation Act (COBRA) rights

The federal COBRA law usually applies to employers of group sizes of 20 or more and gives employees and most of their covered dependents the right to keep their health coverage for 18, 29 or 36 months after a qualifying event. The qualifying event is something that happens that results in you losing your coverage. The qualifying events are:

- Your active employment ends for reasons other than gross misconduct
- Your working hours are reduced
- You divorce or legally separate and are no longer responsible for dependent coverage
- You become entitled to benefits under Medicare
- Your covered dependent children no longer qualify as dependents under the plan
- You die
- You are a retiree eligible for retiree health coverage and your former employer files for bankruptcy

Talk with your employer if you have questions about COBRA or to enroll.

Continuation of coverage

If your coverage ends under this plan, you can continue coverage for you and your covered dependents if:

- Your employer is not required to offer COBRA coverage
- You are not eligible for Medicare
- You are not eligible for any other replacement group coverage
- You are not eligible for or have benefits available under another health care plan
- You have had 3 months of continuous coverage prior to your termination

To continue coverage you must apply through your employer's normal process and pay the required premium within 31 days of the written notice from your employer (but no later than 60 days following the date of termination of your coverage)

Evidence of insurability is not required for you to continue coverage.

The premium will be the current premium rate for the policy. Your employer may charge an administrative fee of no more than 2.0% of the current rate.

You can continue your coverage for 12 months. Each premium must be paid on a monthly basis during the 12-month period.

Extension of coverage for other reasons

To request an extension of coverage, just contact us.

How you can extend coverage if you are totally disabled when coverage ends

Your coverage may be extended if you are totally disabled when coverage ends.

You are "totally disabled" if you cannot work at your occupation or any other occupation for pay or profit.

Your dependent is “totally disabled” if that person cannot engage in most normal activities of a healthy person of the same age and gender.

Upon payment of premium, you may extend coverage in full force until the earliest of:

- When you or your dependents are no longer totally disabled
- When you become covered by another health benefits plan
- 180 days

How you can extend coverage for your disabled child beyond the plan age limits
You have the right to extend coverage for your dependent child beyond plan age limits, if the child is not able to be self-supporting because of mental or physical disability and depends mainly (more than 50% of their income) on you for support.

The right to coverage will continue only as long as a **physician** certifies that your child still is disabled.

We may ask you to send us proof of the disability within 31 days of the date coverage would have ended. Before we extend coverage, we may ask that your child get a physical exam. We will pay for that exam.

We may ask you to send proof that your child is disabled after coverage is extended. We won’t ask for this proof more than once a year. You must send it to us within 31 days of our request. If you don’t, we can terminate coverage for your dependent child.

How you can extend coverage when getting inpatient care when coverage ends
Your coverage may be extended if you are getting inpatient care in a **hospital** or **skilled nursing facility** when coverage ends.

Benefits are extended for the condition that caused the **hospital** or **skilled nursing facility stay** or for complications from the condition. Benefits aren’t extended for other medical conditions.

You can continue to get care for this condition until the earliest of:

- When you are discharged
- When you no longer need inpatient care
- When you become covered by another health benefits plan
- 36 months of coverage

How you can extend coverage for a dependent after you die
Your dependents can continue coverage after your death if:

- You were covered at the time of your death
- The request is made within 30 days after your death, and
- Payment is made for coverage

Your dependent's coverage will end on the earliest date:

- The end of the 12 month period after your death
- They no longer meet the definition of dependent
- Dependent coverage stops under the plan
- The dependent becomes covered by another health benefits plan
- The date your spouse remarries

To request extension of coverage, the dependent, or their representative, can contact us.

General provisions – other things you should know

Administrative provisions

How you and we will interpret this certificate

We prepared this certificate according to XXXXX and other federal and state laws that apply. You and we will interpret it according to these laws. Our interpretation of this certificate applies when we administer your coverage. But you have the right to appeal our decisions as described in the *Complaints, claim decisions and appeal procedures* section.

How we administer this plan

We apply policies and procedures we've developed to administer this plan.

Who's responsible to you

We are responsible to you for what our employees and other agents do.

Network providers are not our employees or agents.

Coverage and services

Your coverage can change

Your coverage is defined by the group agreement. This document may have amendments and riders too. Under certain circumstances, we, the contract holder or the law may change your plan. When an emergency or epidemic is declared, we may modify or waive **precertification**, **prescription** quantity limits or your cost share if you are affected. Only we may waive a requirement of your plan. No other person, including the contract holder or **provider**, can do this.

If a service cannot be provided to you

Sometimes things happen outside of our control. These are things such as natural disasters, epidemics, fire and riots.

We will try hard to get you access to the services you need even if these things happen. But if we can't, we may refund any unearned premium.

Records of expenses

You should keep complete records of your expenses. They may be needed for a claim. Important things to keep are:

- Names of **physicians** and others who furnish services
- Dates expenses are incurred
- Copies of all bills and receipts

Honest mistakes and intentional misrepresentation

Honest mistakes

You or the contract holder may make an honest mistake when you share facts with us. When we learn of the mistake, we may make a fair change in premium contribution or in your coverage. If we do, we will tell you what the mistake was. We won't make a change if the mistake happened more than 2 years from the date of the group agreement.

Intentional misrepresentation

If we learn that you defrauded us or you intentionally misrepresented material facts, we can take actions that can have serious consequences for your coverage. These serious consequences include, but are not limited to:

- Loss of coverage, starting at the effective date of coverage
- Loss of coverage going forward
- Denial of benefits
- Recovery of amounts we already paid

We also may report fraud to law enforcement.

Rescission means you lose coverage both going forward and going backward. If we paid claims for your past coverage, we will want the money back.

You have special rights if we rescind your coverage:

- We will give you 30 days advance written notice of any rescission of coverage. The notice will:
  - Identify the alleged fraudulent act, practice, or omission or the intentional misrepresentation of material fact
  - Explain why the act, practice, or omission was fraud, an omission or an intentional misrepresentation of a material fact
  - Advise you, or your authorized representative, of your right to an Innovation Health appeal
  - Describe our internal appeal process, including any applicable time limits
  - Provide the date the advance notice ends, and the date back to which coverage is lost
- We will refund all premiums you paid

Some other money issues

Assignment of benefits

When you see a **network provider**, they will usually bill us directly. When you see an **out-of-network provider**, we may choose to pay you or to pay the **provider** directly. If we pay you, you are responsible for applying any payment to the claim from the **out-of-network provider**. Except for ambulance services, dentists, and oral surgeons, to the extent allowed by law, we will not accept an assignment to an **out-of-network provider**.

Financial sanctions exclusions

If coverage provided under this certificate violates or will violate any economic or trade sanctions, the coverage will be invalid immediately. For example, we cannot pay for **covered services** if it violates a financial sanction regulation. This includes sanctions related to a person or a country under sanction by the United States, unless it is allowed under a written license from the Office of Foreign Asset Control (OFAC).

You can find out more by visiting https://www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

Recovery of overpayments

We sometimes pay too much for **covered services** or pay for something that this plan doesn't cover. If we do, we can require the person we paid, you or your **provider**, to return what we paid. If we don't do that, we have the right to reduce any future benefit payments by the amount we paid by mistake.

Your health information

We will protect your health information. We will only use or share it with others as needed for your care and treatment. We will also use and share it to help us process your claims and manage your plan.

You can get a free copy of our Notice of Privacy Practices. Just contact us.

When you accept coverage under this plan, you agree to let your **providers** share information with us. We need information about your physical and mental condition and care.

Glossary

Allowable amount
See *How your plan works – What the plan pays and what you pay*.

Behavioral health provider
A **health professional** who is properly licensed or certified to provide **covered services** for mental health and **substance use disorders** in the state where the person practices.

Brand-name prescription drug
An FDA-approved drug marketed with a specific name by the company that manufactures it; often the same company that developed and patents it.

Coinsurance
A percentage paid by a covered person for a **covered service**.

Copay, copayment
A dollar amount or percentage paid by a covered person for a **covered service**.

Covered service
See *Coverage and exclusions – Providing covered services*.

Deductible
The amount a covered person pays for **covered services** per year before we start to pay.

Detoxification
The process of getting alcohol or other drugs out of an addicted person's system and getting them physically stable.

Drug guide
A list of **prescription** drugs and devices established by us or an affiliate. It does not include all **prescription** drugs and devices. This list can be reviewed and changed by us or an affiliate. A copy is available at your request. Go to https://www.innovationhealth.com.

Emergency medical condition
A recent and severe medical condition showing itself by severe symptoms including severe pain that would lead a prudent layperson to reasonably believe, that the condition, illness, or injury is of an urgent nature. And that if you don't get immediate medical care it could result in:

- Placing your physical or mental health in serious danger
- Serious loss to bodily function
- Serious loss of function to a body part or organ
- Serious danger to the health of an unborn child

Emergency services
A medical screening examination given in a **hospital's** emergency room to evaluate an **emergency medical condition**. This includes any additional medical examination and treatment to stabilize the

emergency medical condition. Stabilize means providing treatment to assure the condition will not get worse as a result of, or during, the transfer of the individual from a facility. For a pregnant woman, stabilize also means that the woman has delivered, including the placenta.

Experimental or investigational

Drugs, treatments or tests not yet accepted by **physicians** or by insurance plans as standard treatment. They may not be proven as effective or safe for most people.

A drug, device, procedure or treatment is **experimental or investigational** if:

- There is not enough outcome data available from controlled clinical trials published in the peer-reviewed literature to validate its safety and effectiveness for the illness or injury involved.
- The needed approval by the FDA has not been given for marketing.
- A national medical or dental society or regulatory agency has stated in writing that it is **experimental or investigational** or suitable mainly for research purposes.
- It is the subject of a Phase I, Phase II or the experimental or research arm of a Phase III clinical trial. These terms have the meanings given by regulations and other official actions and publications of the FDA and Department of Health and Human Services.
- Written protocols or a written consent form used by a facility **provider** state that it is **experimental or investigational**.

Formulary exclusions list

A list of **prescription** drugs not covered under the plan. This list is subject to change.

Generic prescription drug

An FDA-approved drug with the same intended use as the brand-name product. It offers the same:

- Dosage
- Safety
- Strength
- Quality
- Performance

Health professional

A person who is authorized by law to provide health care services to the public; for example, **physicians**, nurses and physical therapists.

Home health care agency

An agency authorized by law to provide home health services, such as skilled nursing and other therapeutic services.

Hospital

An institution licensed as a **hospital** by applicable law, and accredited by The Joint Commission (TJC). This is a place that offers medical care. Patients can **stay** overnight for care. Or they can be treated and leave the same day. All **hospitals** must meet set standards of care. They can offer general or acute care. They can also offer service in one area, like rehabilitation.

Infertile, infertility

A disease defined by the failure to become pregnant:

- For a female with a male partner, after:
  - 1 year of frequent, unprotected heterosexual sexual intercourse if under the age of 35

  - 6 months of frequent, unprotected heterosexual sexual intercourse if age 35 or older
- For a female without a male partner, after:
  - At least 12 cycles of donor insemination if under the age of 35
  - 6 cycles of donor insemination if age 35 or older
- For a male without a female partner, after:
  - At least 2 abnormal semen analyses obtained at least 2 weeks apart

Jaw joint disorder

This is:

- A temporomandibular joint (TMJ) dysfunction or any similar disorder of the jaw joint
- A myofascial pain dysfunction (MPD) of the jaw
- Any similar disorder in the relationship between the jaw joint and the related muscles and nerves

Mail order pharmacy

A pharmacy where **prescription** drugs are legally dispensed by mail or other carrier.

Maximum out-of-pocket limit

The **maximum out-of-pocket limit** is the most a covered person will pay per year in **copayments**, **coinsurance** and **deductible**, if any, for **covered services**.

Medically necessary, medical necessity

Health care services that we determine a **provider**, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that we determine are:

- In accordance with generally accepted standards of medical practice
- Clinically appropriate, in terms of type, frequency, extent, and duration, and considered effective for the patient's illness, injury or disease
- Not primarily for the convenience of the patient, **physician**, or other health care **provider**

Generally accepted standards of medical practice means:

- Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community
- Following the standards set forth in our clinical policies and applying clinical judgment

Mental disorder

A **mental disorder** is a condition showing a disturbance in the brain's activities, emotions or behavior. The disturbance affects a person's ability to participate in social, work or other important activities. A complete definition of **mental disorder** is in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association.

Negotiated charge

See *How your plan works – What the plan pays and what you pay*.

Network pharmacy

A **retail pharmacy**, **mail order pharmacy** or **specialty pharmacy** that has contracted with us, an affiliate, or a third party vendor, to provide outpatient **prescription** drugs to you. **Network pharmacy** also includes an out-of-network pharmacy that agrees to accept payment at our contracted network level

rates as payment in full. The out-of-network pharmacy or its intermediary must notify us in writing, by fax or otherwise, of their agreement.

Network provider
A **provider** listed in the directory for your plan. A NAP **provider** listed in the NAP directory is not a **network provider**.

Out-of-network provider
A **provider** who is not a **network provider**.

Partial hospitalization treatment
Clinical treatment at a minimum of 4 or more continuous hours per treatment day for medically necessary services provided by a **behavioral health provider** with the appropriate license or credentials. Services are designed to address a **mental disorder** or **substance use disorder** issue and may include:

- Group, individual, family or multi-family group psychotherapy
- Psycho-educational services
- Adjunctive services such as medication monitoring

Treatment includes intensive outpatient programs for the treatment of alcohol or other drug dependence which provide treatment over a period of three or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients.

Care is delivered according to accepted medical practice for the condition of the person.

Physician
A **health professional** trained and licensed to practice and prescribe medicine under the laws of the state where they practice; specifically, doctors of medicine or osteopathy. Under some plans, a **physician** can also be a **primary care physician** (**PCP**).

Precertification, precertify
Pre-approval that you or your **provider** receives from us before you receive certain **covered services**. This may include a determination by us as to whether the service is **medically necessary** and eligible for coverage.

Preferred drug
A **prescription** drug or device that may have a lower out-of-pocket cost than a non-preferred drug.

Prescription
This is an instruction written by a **physician** that authorizes a patient to receive a service, supply, medicine or treatment.

Primary care physician (PCP)
A **physician** who:

- The directory lists as a **PCP**
- Is selected by a person from the list of **PCP**s in the directory
- Supervises, coordinates and provides initial care and basic medical services to a person
- Initiates **referrals** for **specialist** care, if required by the plan, and maintains continuity of patient care
- Shows in our records as your **PCP**

A **PCP** can be any of the following **providers**:

- General practitioner
- Family **physician**
- Internist
- Pediatrician
- Obstetrician (OB), Gynecologist (GYN), and Obstetrician/Gynecologist (OB/GYN)

Provider

A **physician**, **health professional**, person, or facility, licensed or certified by law to provide health care services to you. If state law does not specifically provide for licensure or certification, they must meet all Medicare approval standards even if they don't participate in Medicare.

Psychiatric hospital

An institution licensed or certified as a **psychiatric hospital** by applicable laws to provide a program for the diagnosis, evaluation, and treatment of alcoholism, drug abuse or **mental disorders** (including **substance use disorders**).

Referral

This only applies to in-network coverage and is a written or electronic authorization made by your **PCP** to direct you to a **network provider** for **medically necessary** services and supplies.

Residential treatment facility

An institution specifically licensed as a **residential treatment facility** by applicable laws to provide for mental health or **substance use disorder** residential treatment programs. It is credentialed by us or is accredited by one of the following agencies, commissions or committees for the services being provided:

- The Joint Commission (TJC)
- The Committee on Accreditation of Rehabilitation Facilities (CARF)
- The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP)
- The Council on Accreditation (COA)

In addition to the above requirements, an institution must meet the following:
For residential treatment programs treating **mental disorders**:

- A **behavioral health provider** must be actively on duty 24 hours/day for 7 days/week
- The patient must be treated by a psychiatrist at least once per week
- The medical director must be a psychiatrist
- It is not a wilderness treatment program (whether or not the program is part of a licensed **residential treatment facility** or otherwise licensed institution)

For **substance use** residential treatment programs:

- A **behavioral health provider** or an appropriately state certified professional (CADC, CAC, etc.) must be actively on duty during the day and evening therapeutic programming
- The medical director must be a **physician**
- It is not a wilderness treatment program (whether or not the program is part of a licensed **residential treatment facility** or otherwise licensed institution)

For **detoxification** programs within a residential setting:

- An R.N. must be onsite 24 hours/day for 7 days/week within a residential setting
- Residential care must be provided under the direct supervision of a **physician**

Retail pharmacy

A community pharmacy that dispenses outpatient **prescription** drugs at retail prices.

Room and board

A facility's charge for your overnight **stay** and other services and supplies expressed as a daily or weekly rate.

Semi-private room rate

An institution's **room and board** charge for most beds in rooms with 2 or more beds. If there are no such rooms, we will calculate the rate based on the rate most commonly charged by similar institutions in the same geographic area.

Skilled nursing facility

A facility specifically licensed as a **skilled nursing facility** by applicable laws to provide skilled nursing care. **Skilled nursing facilities** also include:

- Rehabilitation **hospitals**
- Portions of a rehabilitation **hospital**
- A **hospital** designated for skilled or rehabilitation services

Skilled nursing facility does not include institutions that provide only:

- Minimal care
- Custodial care
- Ambulatory care
- Part-time care

Skilled nursing services

Services provided by a registered nurse or licensed practical nurse within the scope of their license.

Specialist

A **physician** who practices in any generally accepted medical or surgical sub-specialty.

Specialty prescription drugs

These are **prescription** drugs that include typically high-cost drugs that require special handling, special storage or monitoring and may include things such as oral, topical, inhaled and injected routes of administration. You can contact us to access the list of specialty drugs, including biosimilar **prescription** drugs.

Specialty pharmacy

This is a pharmacy designated by us as **a network pharmacy** to fill **prescriptions** for **specialty prescription drugs**.

Stay

A full-time inpatient confinement for which a **room and board** charge is made.

Step therapy

A form of **precertification** under which certain **prescription** drugs are excluded from coverage, unless a first-line therapy drug is used first by you. The list of **step therapy** drugs is subject to change by us or an affiliate. An updated copy of the list of drugs subject to **step therapy** is available upon request or on our website at https://www.innovationhealth.com.

Substance use disorder

This is a physical or psychological dependency, or both, on a drug or alcohol. These are defined in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) published by the American Psychiatric Association. This term does not include an addiction to nicotine products, food or caffeine.

Surgery, surgical procedure

The diagnosis and treatment of injury, deformity and disease by manual and instrumental means, such as:

- Cutting
- Abrading
- Suturing
- Destruction
- Ablation
- Removal
- Lasering
- Introduction of a catheter (e.g., heart or bladder catheterization) or scope (e.g., colonoscopy or other types of endoscopy)
- Correction of fracture
- Reduction of dislocation
- Application of plaster casts
- Injection into a joint
- Injection of sclerosing solution
- Otherwise physically changing body tissues and organs

Telemedicine

A consultation between you and a **provider** who is performing a clinical medical or behavioral health service that can be provided electronically by:

- Two-way audiovisual teleconferencing
- Any other method required by law, including remote patient monitoring

Remote patient monitoring means the delivery of home health services using telecommunications technology, including:

- Monitoring clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose, and other condition-specific data
- Medication adherence monitoring
- Interactive video conferencing with or without digital image upload

Terminal illness

A medical prognosis that you are not likely to live more than 6-24 months.

Urgent condition

An illness or injury that requires prompt medical attention but is not a life-threatening **emergency medical condition**.

Value prescription drugs

A group of medications determined by us that may be available at a reduced **copayment** or **coinsurance** and are noted on the **drug guide**.

Walk-in clinic

A freestanding health care facility. The following are not considered a **walk-in clinic**:

- Emergency room
- Urgent care facility
- The outpatient department of a **hospital**

Innovation Health Plan, Inc.
Underwritten by Innovation Health Plan, Inc. in the Commonwealth of Virginia

Amendment

Contract holder: VIRGINIA INDEPENDENT SCHOOLS CONSORTIUM

Amendment effective date: 10/01/2022

Your group agreement has changed. The certificate of coverage, schedule of benefits and riders are revised to reflect this. This change is effective on the date shown above.

The changes are as follows:

The following language is revised in the *Welcome, Wellness and other rewards* section of your certificate:

Wellness and other rewards

You may be eligible to earn rewards for completing certain activities that improve your health, coverage, and experience with us. We may encourage you to access certain health services, or categories of healthcare **providers**, participate in programs, including but not limited to financial wellness programs; utilize tools, improve your health metrics or continue participation as an Innovation Health, Inc. member through incentives. Talk with your **provider** about these and see if they are right for you. We may provide incentives based on your participation and outcomes such as:

- Modifications to **copayment**, **deductible** or **coinsurance** amounts
- Contributions to your health savings account
- Merchandise
- Coupons
- Gift or debit cards
- Any combination of the above

The following language is removed from the *Coverage and exclusions*, *Applied behavior analysis* section of your certificate:

> The following are not **covered services**:
> Early intensive behavioral interventions, such as Denver, LEAP, TEACCH, Rutgers, floor time, Lovaas and similar programs, and other intensive educational interventions

The following language in the first bullet point is revised within the *Coverage and exclusions*, *Mental health treatment* section of your certificate:

Mental health treatment

Covered services include the treatment of **mental disorders** provided by a **hospital**, **psychiatric hospital**, **residential treatment facility**, **physician,** or **behavioral health provider** including:

- Inpatient **room and board** at the **semi-private room rate**, (your plan will cover the extra expense of a private room when appropriate because of your medical condition), and other services and supplies related to your condition that are provided during your **stay** in a **hospital**, **psychiatric hospital**, or **residential treatment facility**

The following language is revised within the *Coverage and exclusions*, *Preventive care, Family planning services – female contraceptives* section of your certificate:

Family planning services – female contraceptives

Covered services include family planning services as follows:

- Counseling services provided by a **physician** on contraceptive methods. These will be covered when you get them in either a group or individual setting.
- Contraceptive devices (including any related services or supplies) when they are provided, administered, or removed by a **physician** during an office visit.
- Voluntary sterilization including charges billed separately by the **provider** for female voluntary sterilization procedures and related services and supplies. This also could include tubal ligation and sterilization implants.

The following are not preventive **covered services**:

- Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA
- Male contraceptive methods, sterilization procedures or devices

The following language in the first bullet point is revised within the *Coverage and exclusions*, *Substance use disorders treatment* section of your certificate:

Substance use disorders treatment

Covered services include the treatment of **substance use disorders** provided by a **hospital**, **psychiatric hospital**, **residential treatment facility**, **physician**, or **behavioral health provider** as follows:

- Inpatient **room and board**, at the **semi-private room rate**, (your plan will cover the extra expense of a private room when appropriate because of your medical condition), and other services and supplies that are provided during your **stay** in a **hospital**, **psychiatric hospital**, or **residential treatment facility**. Treatment of **substance use disorders** in a general medical **hospital** is only covered if you are admitted to the **hospital's** separate **substance use disorders** section or unit, unless you are admitted for the treatment of medical complications of **substance use disorders**.

The following language is added in the *Coverage and exclusions*, *Short-term rehabilitation services* section of your certificate:

Short-term rehabilitation services

Short-term physical, speech and occupational therapy services provided in an outpatient setting are subject to the same conditions and limitations for outpatient short-term rehabilitation services. See the *Short-term rehabilitation services* section in the schedule of benefits.

The following language is removed from the *General plan exclusions* section of your certificate:

Counseling

Marriage, religious, family, career, social adjustment, pastoral or financial counseling

The following language is revised within the *General plan exclusions* section of your certificate:

Court-ordered services and supplies

This includes court-ordered services and supplies, or those required as a condition of parole, probation, release or because of any legal proceeding, unless they are a **covered service** under your plan

The benefit exclusion named *Mental health treatment* within the *General plan exclusions* of your certificate is renamed to *Behavioral health treatment* and will be included in the certificate in the correct alphabetical order. In this renamed section, the following content has been added:

Behavioral health treatment

Services for the following categories (or equivalent terms as listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association):

- **Stay** in a facility for treatment for dementias or amnesia without a behavioral disturbance that necessitates mental health treatment
- School and/or education service, including special education, remedial education, wilderness treatment programs or any such related or similar programs
- Services provided in conjunction with school, vocation, work or recreational activities
- Transportation

The following new section is added to the *General plan exclusions* section of your certificate:

Mental health and substance use disorders treatment

The following conditions/diagnoses (or equivalent terms as listed in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association) are not covered by the behavioral health plan:

- Sexual deviations and disorders except for gender identity disorders
- Tobacco use disorders and nicotine dependence except as described in the *Coverage and exclusions, Preventive care* section
- Pathological gambling, kleptomania, and pyromania
- Specific developmental disorders of scholastic skills (Learning Disorders/Learning Disabilities)
- Specific developmental disorder of motor functions
- Specific developmental disorders of speech and language
- Other disorders of psychological development

The following language is revised in the *Precertification*, *Types of services that require precertification* section of your certificate:

Types of services that require precertification

Precertification is required for inpatient stays and certain outpatient services and supplies.

Precertification is required for the following types of services and supplies:

Inpatient services and supplies	Outpatient services and supplies
Stays in a **hospital**	Complex imaging
Stays in a **skilled nursing facility**	**Cosmetic** and reconstructive **surgery**
Stays in a **rehabilitation facility**	Emergency transportation by airplane
Stays in a **hospice** facility	Injectables, (immunoglobulins, growth hormones, multiple sclerosis medications, osteoporosis medications, Botox , hepatitis C medications)
Stays in a residential treatment facility for treatment of **mental disorders** and **substance related disorders**	Kidney dialysis
Obesity (bariatric) **surgery**	Outpatient back **surgery** not performed in a **physician's** office
	Sleep studies
	Knee **surgery**
	Wrist **surgery**

	Transcranial magnetic stimulation (TMS)
	Applied behavioral analysis
	Partial hospitalization treatment – **mental disorder** and **substance related disorders treatment** diagnoses

Contact us to get a list of the services that require **precertification**. The list may change from time to time.

The following language under *How your plan works*, *What the plan pays and what you pay*, *Negotiated charge* section of your certificate is revised within the first paragraph. All other language remains the same:

Negotiated charge

For health coverage:

This is the amount a **network provider** has agreed to accept or that we have agreed to pay them or a third-party vendor (including any administrative fee in the amount paid).

The following language is revised in the *Glossary* section of your certificate:

Primary care physician (PCP)

A **physician** who:

- The directory lists as a **PCP**
- Is selected by a person from the list of **PCP**s in the directory
- Supervises, coordinates and provides initial care and basic medical services to a person
- Initiates **referrals** for **specialist** care, if required by the plan, and maintains continuity of patient care
- Shows in our records as your **PCP**

A **PCP** can be any of the following **providers**:

- General practitioner
- Family **physician**
- Internist
- Pediatrician
- Obstetrician (OB), Gynecologist (GYN), and Obstetrician/Gynecologist (OB/GYN)
- Medical group (primary care office)

The following section is removed from the *Covered services*, *Habilitation therapy services* section of your schedule of benefits:

Habilitation therapy

Description	In-network	Out-of-network
Habilitation therapy	Covered based on type of service and where it is received	Covered based on type of service and where it is received

The following language is added to the *Other outpatient services* benefit in the *Covered services*, *Mental health treatment* and *Substance use disorders treatment* sections of your schedule of benefits:

Description
Other outpatient services including: • Behavioral health services in the home • Partial hospitalization treatment • Intensive outpatient program The cost share doesn't apply to in-network peer counseling support services

The following descriptive language is revised from "Inpatient services-room and board" to "inpatient services and supplies" in the *Transplant services* section of your schedule of benefits:

Transplant services

Description
Inpatient services and supplies

The following language is added to the adult vision care and pediatric vision care visit limitation in the *Vision* section of your schedule of benefits:

Visit limit	1 visit(s) every 12 months	1 visit(s) every 12 months

The following language is added within the *What you need to know about the prescription drug plan* section of the Outpatient Drug Plan Rider:

Prescription drug synchronization

If you are prescribed multiple maintenance medications and would like to have them each dispensed on the same fill date for your convenience, your **pharmacy** can coordinate that for you. This is called synchronization. We will apply a prorated daily cost share rate, to a partial fill of a maintenance drug, if needed, to synchronize your **prescription drugs**.

Innovation Health Plan, Inc.

Amendment

Effective date: 10/01/2022

Your coverage has changed. This amendment shows the changes made to your certificate of coverage. It's effective on the date shown above. The changes appear below.

The *Mental health treatment* and *Substance use disorders treatment* provisions in the *Coverage and exclusions* section are revised and combined into the following provision:

Behavioral health

Mental health treatment

Covered services include the treatment of **mental health disorders** provided by a **hospital**, **psychiatric hospital**, **residential treatment facility**, **physician,** or **behavioral health provider** including:

- Inpatient **room and board** at the **semi-private room rate** (your plan will cover the extra expense of a private room when appropriate because of your medical condition), and other services and supplies related to your condition that are provided during your **stay** in a **hospital**, **psychiatric hospital**, or **residential treatment facility**
- Outpatient treatment received while not confined as an inpatient in a **hospital**, **psychiatric hospital**, or **residential treatment facility**, including:
  - Office visits to a **physician** or **behavioral health provider** such as a psychiatrist, psychologist, social worker, or licensed professional counselor (includes **telemedicine** consultation)
  - Individual, group, and family therapies for the treatment of **mental health disorders**
  - Other outpatient mental health treatment such as:
    - Partial hospitalization treatment provided in a facility or program for mental health treatment provided under the direction of a **physician**
    - Intensive outpatient program provided in a facility or program for mental health treatment provided under the direction of a **physician**
    - Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
      - You are homebound
      - Your **physician** orders them
      - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home
      - The skilled behavioral health care is appropriate for the active treatment of a condition, illness, or disease
    - Electro-convulsive therapy (ECT)
    - Transcranial magnetic stimulation (TMS)
    - Psychological testing

- Neuropsychological testing
- Observation
- Peer counseling support by a peer support specialist

A peer support specialist serves as a role model, mentor, coach, and advocate. They must be certified by the state where the services are provided, or a private certifying organization recognized by us. Peer support must be supervised by a **behavioral health provider**.

Substance use disorders treatment

Covered services include the treatment of **substance use disorders** provided by a **hospital**, **psychiatric hospital**, **residential treatment facility**, **physician**, or **behavioral health provider** as follows:

- Inpatient **room and board**, at the **semi-private room rate** (your plan will cover the extra expense of a private room when appropriate because of your medical condition), and other services and supplies that are provided during your **stay** in a **hospital**, **psychiatric hospital**, or **residential treatment facility**.
- Outpatient treatment received while not confined as an inpatient in a **hospital**, **psychiatric hospital**, or **residential treatment facility**, including:
  - Office visits to a **physician** or **behavioral health provider** such as a psychologist, social worker, or licensed professional counselor (includes **telemedicine** consultation)
  - Individual, group, and family therapies for the treatment of **substance use disorders**
  - Other outpatient **substance use disorders** treatment such as:
    - Partial hospitalization treatment provided in a facility or program for treatment of **substance use disorders** provided under the direction of a **physician**
    - Intensive outpatient program provided in a facility or program for treatment of **substance use disorders** provided under the direction of a **physician**
    - Ambulatory or outpatient **detoxification** which include outpatient services that monitor withdrawal from alcohol or other substances, including administration of medications
    - Observation
    - Peer counseling support by a peer support specialist

A peer support specialist serves as a role model, mentor, coach, and advocate. They must be certified by the state where the services are provided, or a private certifying organization recognized by us. Peer support must be supervised by a **behavioral health provider**.

The *Hearing exams* provision is removed in the *Coverage and exclusions* section:

Hearing exams

Covered services include hearing exams for evaluation and treatment of illness, injury or hearing loss when performed by a hearing **specialist**.

The following are not **covered services**:

- Hearing exams given during a **stay** in a **hospital** or other facility, except those provided to newborns as part of the overall **hospital stay**

The *Important note* is added to the *Physician services* provision in the *Coverage and exclusions* section:

Important note:
For behavioral health services, all in-person, **covered services** with a **behavioral health provider** are also **covered services** if you use **telemedicine** instead.

The *Routine physical exams* provision in the *Coverage and exclusions*, *Preventive care* section is revised as follows:

Preventive care

Routine physical exams

A routine preventive exam is a medical exam given for a reason other than to diagnose or treat a suspected or identified illness or injury and also includes:

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.
- Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.
- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
  - Screening and counseling services on topics such as:
    - Interpersonal and domestic violence
    - Sexually transmitted diseases
    - Human immune deficiency virus (HIV) infections
  - High risk human papillomavirus (HPV) DNA testing for women

Covered services include:

- Office visit to a **physician**
- Hearing screening
- Vision screening
- Radiological services, lab and other tests
- For covered newborns, an initial **hospital** checkup

The *Reconstructive surgery and supplies* provision in the *Coverage and exclusions* section is revised as follows:

Reconstructive surgery and supplies

Covered services include all stages of reconstructive **surgery** by your **provider** and related supplies provided in an inpatient or outpatient setting only in the following circumstances:

- Your **surgery** is to implant or attach a covered prosthetic device.
- Your **surgery** corrects a congenital defect or birth abnormality, including but not limited to cleft lip, cleft palate or ectodermal dysplasia. The **surgery** will be covered if:
  - The defect results in facial disfigurement or functional impairment of a body part
  - The purpose of the **surgery** is to improve function

- Your **surgery** is needed because treatment of your illness resulted in severe facial disfigurement or major functional impairment of a body part, and your **surgery** will improve function.

Covered services also include the procedures or surgery to sound natural teeth**,** injured due to an accident and performed as soon as medically possible, when:

- The teeth were stable, functional and free from decay or disease at the time of the injury.
- The **surgery** or procedure returns the injured teeth to how they functioned before the accident.

These dental related services are limited to:

- The first placement of a permanent crown or cap to repair a broken tooth
- The first placement of dentures or bridgework to replace lost teeth
- Orthodontic therapy to pre-position teeth

The *Transplant services* provision in the *Coverage and exclusions* section is revised as follows:

Transplant services

Covered services include transplant services provided by a **physician** and **hospital**.

This includes the following transplant types:

- Solid organ
- Hematopoietic stem cell
- Bone marrow
- CAR-T and T Cell receptor therapy for FDA-approved treatments
- Thymus tissue for FDA-approved treatments

Network of transplant facilities

We designate facilities to provide specific services or procedures. They are listed as Institutes of Excellence™ (IOE) facilities in your **provider** directory.

You must get transplant services from the IOE facility we designate to perform the transplant you need. Transplant services received from an IOE facility are subject to the network **copayment**, **coinsurance**, **deductible**, **maximum out-of-pocket** and limits, unless stated differently in this certificate and schedule of benefits.

Important note:
If there are no IOE facilities assigned to perform your transplant type in your network, it's important that you contact us so we can help you determine if there are other facilities that may meet your needs. If you don't get your transplant services at the facility we designate, they will not be **covered services**.

Many pre and post-transplant medical services, even routine ones, are related to and may affect the success of your transplant. If your transplant care is being coordinated by the National Medical Excellence® (NME) program, all medical services must be managed through NME so that you receive the highest level of benefits at the appropriate facility. This is true even if the **covered service** is not directly related to your transplant.

The following are not **covered services**:

- Services and supplies furnished to a donor when the recipient is not a covered person
- Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing illness
- Harvesting and/or storage of bone marrow, hematopoietic stem cells, or other blood cells without intending to use them for transplantation within 12 months from harvesting, for an existing illness

The *walk-in clinic* provision in the *Coverage and exclusions* section is revised as follows:

Walk-in clinic

Covered services include, but are not limited to, health care services provided at a **walk-in clinic** for:

- Scheduled and unscheduled visits for illnesses and injuries that are not **emergency medical conditions**
- Preventive care immunizations administered within the scope of the clinic's license
- Individual screening and counseling services that will help you:
  - With obesity or healthy diet
  - To stop using tobacco products

The *Nutritional support* provision is revised in the *Coverage and exclusions* section:

Nutritional support

Covered services include formula and enteral nutrition products for the treatment of an inherited metabolic disorder.

An inherited metabolic disorder is an inherited enzymatic disorder caused by single gene defects involved in the metabolism of amino, organic, or fatty acids.

Covered services include:

- Formula and enteral nutrition products that:
  - Are liquid or solid formulas and enteral nutrition products for the partial or exclusive feeding by means of oral intake or enteral feeding by tube
  - A **physician** or other **health professional** that is qualified for the management of an inherited metabolic disorder has issued a written notice stating that the formula or enteral nutrition product is **medically necessary**
  - Are a critical source of nutrition as certified by the **physician** by diagnosis, but do not need to be the covered person's primary source of nutrition
  - Are proven effective as a treatment regimen for the covered person
  - Are used under medical supervision which may include a home setting
- Medical equipment, supplies, and services that are required to administer the covered formula or enteral nutrition products

The following are not **covered services**:

- Any other food item, including:
  - Infant formulas
  - Nutritional supplements
  - Vitamins

- Medical foods
- Other nutritional items

The *Behavioral health treatment* provision in the *General plan exclusions* section is revised as follows:

Behavioral health treatment

Services for the following based on categories, conditions, diagnoses or equivalent terms as listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association:

- **Stay** in a facility for treatment for dementia and amnesia without a behavioral disturbance that necessitates mental health treatment
- School and/or education service, including special education, remedial education, wilderness treatment programs, or any such related or similar programs
- Services provided in conjunction with school, vocation, work or recreational activities
- Transportation
- Sexual deviations and disorders except for gender identity disorders
- Tobacco use disorders and nicotine dependence except as described in the *Coverage and exclusions, Preventive care* section
- Pathological gambling, kleptomania, and pyromania
- Specific developmental disorders of scholastic skills (Learning Disorders/Learning Disabilities)
- Specific developmental disorder of motor functions
- Specific developmental disorders of speech and language
- Other disorders of psychological development

The following is added to the *General plan exclusions* section:

Hearing exams

Hearing exams performed for the evaluation and treatment of illness, injury or hearing loss.

The following provision is removed in the *General plan exclusions* section:

Nutritional support

- Any food item, including:
  - Infant formulas
  - Nutritional supplements
  - Vitamins
  - **Prescription** vitamins
  - Medical foods
  - Other nutritional items

even if it is the sole source of nutrition

The *Telemedicine* provision in the *General plan exclusions* section is revised as follows:

Telemedicine

- Services given when you are not present at the same time as the **provider**
- Telephone calls
- **Telemedicine** kiosks
- Electronic vital signs monitoring or exchanges (e.g. Tele-ICU, Tele-stroke)

The *Types of services that require precertification* provision in the *How your plan works, Medical necessity and precertification requirements, Precertification* section is revised as follows:

Types of services that require precertification
Precertification is required for inpatient **stays** and certain outpatient services and supplies.

Precertification is required for the following types of services and supplies:

Inpatient services and supplies	Outpatient services and supplies
Obesity (bariatric) **surgery**	Applied behavioral analysis
Stays in a **hospice** facility	Complex imaging
Stays in a **hospital**	**Cosmetic** and reconstructive **surgery**
Stays in a **rehabilitation facility**	Emergency transportation by airplane
Stays in a **residential treatment facility** for treatment of **mental health disorders** and **substance use disorders** treatment	Injectables, (immunoglobulins, growth hormones, multiple sclerosis medications, osteoporosis medications, Botox, hepatitis C medications)
Stays in a **skilled nursing facility**	Kidney dialysis
	Knee **surgery**
	Outpatient back **surgery** not performed in a **physician's** office
	Partial hospitalization treatment – **mental health disorder** and **substance use disorders** treatment
	Sleep studies
	Transcranial magnetic stimulation (TMS)
	Wrist **surgery**

Contact us to get a list of the services that require **precertification**. The list may change from time to time.

The following language in the *How your plan works*, *Medical necessity and precertification requirements* section is revised as follows:

Sometimes you or your **provider** may ask for a medical exception for drugs that are not covered or for which coverage was denied. You, someone who represents you or your **provider** can contact us. Your **provider** will need to provide us with clinical documentation. After we receive the request and any information, we will:

- Review and act upon the request for the prescription, (including prescriptions to alleviate cancer pain), within 24 hours, which includes hours on weekends, where urgent circumstances apply.
- Tell you and your **provider** of our coverage determination within 72 hours, including hours on weekends.

Any exception granted is based upon an individual and is a case-by-case decision that will not apply to other members. If approved by us, you will receive the exception for the entire time of the **prescription**. See the *Prescription drug plan rider* for additional information.

For directions on how you can submit a request for a review:

- Call the toll-free number on your ID card
- Log in to the website at https://www.innovationhealth.com/
- Submit the request in writing to CVS Health ATTN: Innovation Health PA, 1300 E Campbell Road, Richardson, TX 75081

You, someone who represents you or your **provider** may seek a quicker medical exception when the situation is urgent. It's an urgent situation when you have a health condition that may seriously affect your life, health, or ability to get back maximum function. It can also be when you are going through a current course of treatment using a non-covered drug.

If we deny your request for a medical exception, including **step therapy,** you have the right to request an external review by an Independent Review Organization (IRO). The IRO will tell you and your **provider** of the coverage decision no later than 72 hours (including hours on weekends) after we receive your request. For urgent situations, we will tell you or your **provider** of the coverage decision no later than 24 hours (including hours on weekends) after we receive your request. If the IRO approves your request, coverage will be provided for the entire time you have an urgent situation. If the IRO denies your request, you have the right to appeal the decision.

The *Allowable amount* provision in the *How your plan works, What the plan pays and what you pay* section is revised as follows:

Allowable amount

This is the amount of an **out-of-network provider's** charge that is eligible for coverage. You are responsible for all charges above this amount. The **allowable amount** depends on the geographic area where you get the service or supply. **Allowable amount** doesn't apply to involuntary services. These are services or supplies that are:

- Provided at a network facility by an **out-of-network provider**
- Not available from a **network provider**
- An **emergency service**

We will calculate your cost share for involuntary services in the same way as we would if you received the services from a **network provider**. See the *Balance billing protection for out-of-network services* provision for more information on some of these services.

The table below shows the method for calculating the **allowable amount** for specific services or supplies.

Service or supply:	**Allowable amount is based on:**
Professional services and other services or supplies not mentioned below	105% of the Medicare Allowable Rate
Services of **hospitals** and other facilities	140% of the Medicare Rate

Important note:
See Special terms used, below, for a description of what the **allowable amount** is based on.
If the **provider** bills less than the amount calculated using a method above, the **allowable amount** is what the **provider** bills

If your ID card displays the National Advantage Program (NAP) logo, your cost share may be lower when you get care from a NAP **provider**. These are **out-of-network providers** and third party vendors who have contracts with us but are not **network providers**. When you get care from a NAP **provider**, your **out-of-network** cost share applies.

Special terms used:

- Geographic area is normally based using the first three digits of a zip code. If we believe we need more data for a particular service or supply, we may base rates on a wider geographic area such as the entire state.
- Medicare allowed rates are the rates CMS establishes for services and supplies provided to Medicare enrollees without taking into account adjustments for specific **provider** performance. We update our system with these when revised within 180 days of receiving them from CMS. If Medicare doesn't have a rate, we use one or more of the items below to determine the rate for a service or supply:
  - The method CMS uses to set Medicare rates
  - How much other **providers** charge or accept as payment
  - How much work it takes to perform a service
  - Other things as needed to decide what rate is reasonable

Our reimbursement policies

We have the right to apply our reimbursement policies to all out-of-network services including involuntary services. This may affect the **allowable amount**. When we do this, we consider:

- The length and difficulty of a service
- Whether additional expenses are needed, when multiple procedures are billed at the same time
- Whether an assistant surgeon is needed
- If follow up care is included
- Whether other conditions change or make a service unique
- Whether any of the services described by a claim line are part of or related to the primary service provided, when a charge includes more than one claim line
- The educational level, licensure or length of training of the **provider**

We base our reimbursement policies on our review of:

- CMS National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and aren't appropriate
- Generally accepted standards of medical and dental practice
- The views of **physicians** and dentists practicing in relevant clinical areas

We use commercial software to administer some of these policies. Policies may differ for professional services and facility services.

Get the most from your benefits:
We have online tools to help you decide whether to get care and if so, where. Log in to your member website. The website contains additional information that can help you determine the cost of a service or supply.

The following paragraph in the *Precertification* provision in the *How your plan works*, *Medical necessity and precertification requirements* section is revised as follows:

Timeframes for **precertification** are listed below. For **emergency services**, including interhospital transfer of a newborn with a life-threatening emergency condition or their hospitalized mother to accompany the newborn, **precertification** is not required, but you should notify us as shown.

The following provision is removed in the *General provisions – other things you should know, Coverage and services* section:

If a service cannot be provided to you

Sometimes things happen outside of our control. These are things such as natural disasters, epidemics, fire and riots.

We will try hard to get you access to the services you need even if these things happen. But if we can't, we may refund any unearned premium.

The *Behavioral health provider* provision in the *Glossary* section is revised as follows:

Behavioral health provider

A **health professional** who is licensed or certified to provide **covered services** for mental health and **substance use disorders** in the state where the person practices.

The *Infertile, infertility* provision in the *Glossary* section is revised as follows:

Infertile, infertility

A disease defined by the failure to become pregnant:

- For a female with a male partner, after:
  - 1 year of frequent, unprotected heterosexual sexual intercourse if under the age of 35
  - 6 months of frequent, unprotected heterosexual sexual intercourse if age 35 or older
- For a female without a male partner, after:
  - At least 12 cycles of donor insemination if under the age of 35
  - 6 cycles of donor insemination if age 35 or older
- For a male without a female partner, after:
  - At least 2 abnormal semen analyses obtained at least 2 weeks apart
- For an individual or their partner who has been clinically diagnosed with gender identity disorder

The *Mental disorder* provision in the *Glossary* section is revised as follows:

Mental health disorder

A **mental health disorder** is, in general, a set of symptoms or behavior associated with distress and interference with personal function. A complete definition of **mental health disorder** is in the most recent edition of *Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association*.

The *Walk-in clinic* provision in the *Glossary* section is revised as follows:

Walk-in clinic

A health care facility that provides limited medical care on a scheduled and unscheduled basis. A **walk-in clinic** may be located in, near or within a:

- Drug store
- Pharmacy
- Retail store
- Supermarket

The following are not considered a **walk-in clinic**:

- Ambulatory surgical center
- Emergency room
- **Hospital**
- Outpatient department of a **hospital**
- Physician's office
- Urgent care facility

The following provision is removed in the *Coverage and exclusions, Emergency services* section:

Non-emergency services

If you go to an emergency room for what is not an **emergency medical condition**, the plan may not cover your expenses. See the schedule of benefits for this information.

The following are not **covered services**:

- Non-emergency care in a **hospital** emergency room, except for initial screening, evaluation and stabilization

The *Out-of-network providers* provision in the *How your plan works, Who provides the care* section is revised as follows:

Out-of-network providers

You can also get care from **out-of-network providers**. When you use an **out-of-network provider**, your cost share is higher except for **emergency services** from an **out-of-network provider** and non-emergency services from an **out-of-network provider** at an in-network facility. You are responsible for:

- Your out-of-network **deductible**
- Your out-of-network **coinsurance**
- Any charges over the **allowable amount**
- Submitting your own claims and getting **precertification**

See the *Balance billing protection for out-of-network services* provision for more information.

The following provision is added to the *How your plan works, What the plan pays and what you pay* section:

Balance billing protection for out-of-network services

While you're in Virginia, you are protected from balance billing by an **out-of-network provider** for certain services.

What is balance billing?
You're responsible for certain cost-sharing amounts such as **deductibles**, **copayments** and **coinsurance** for covered services. An **out-of-network provider** may have billed a charge that exceeds the amount paid by us plus your cost-sharing amounts. A balance bill occurs if the **provider** bills you for payment of this balance.

When you cannot be balance billed
An **out-of-network provider** cannot balance bill or attempt to collect costs from you that exceed your in-network cost-sharing requirements, such as **deductibles**, **copayments** and **coinsurance** for the following services:

- **Emergency services** provided by an **out-of-network provider**. Your final diagnosis will not determine whether services are **emergency services**.
- Non-emergency surgical or ancillary services provided by an **out-of-network provider** at an in-network facility. This includes professional services, including surgery, anesthesiology, pathology, radiology, or hospitalist services and lab services.

We will:

- Pay the **out-of-network provider** based on a commercially reasonable amount, based on payments for the same or similar services provided in a similar geographic area
- Base your in-network cost-sharing requirement on what we usually pay a **network provider**
- Count any amounts you are responsible for under this protection toward the in-network **maximum out-of-pocket limit**

If you pay an amount that exceeds this, the **provider** must refund that amount with interest. If you are billed an amount that exceeds your payment responsibility stated on your explanation of benefits or you believe you've been wrongly billed, you can file a complaint with the State Corporation Commission's Virginia Bureau of Insurance at https://scc.virginia.gov/pages/File-Complaint-Consumers or call 1-877-310-6560.

When you can be balance billed
If you receive services from an **out-of-network provider** or facility in any other situation, you may be responsible for paying:

- Your **out-of-network deductible**, **copayment** and **coinsurance** that apply
- Any charges over our **allowable amount**

See the *Who provides the care – Out-of-Network providers* section for more information.

This amendment makes no other changes to the certificate of coverage.

Innovation Health Plan, Inc.

Amendment IP HC COCAmend-2021 01
Amends form: HC HCOC 06

Important Information about the Affordable Care Act (ACA)

Non-discrimination Rule

The Office of Civil Rights recently issued a Non-discrimination Rule in response to Section 1557 of the Affordable Care Act (ACA). Section 1557 prohibits discrimination because of race, color, national origin, sex, age or disability in health-related insurance or other health-related coverage. This applies to Innovation Health. Changes to health insurance plans are effective on the first day of the policy or plan year beginning on or after January 1, 2017.

Some language changes may not be in the enclosed certificate of coverage or policy. This may be because the language is still under official review for approval. See the *Important note* below for how this affects your policy or plan.

Important note:
We will comply with the requirements of the Rule for all new and renewing policies or plans with an effective date on or after January 1, 2017.

Below is a summary of some of the recent Non-discrimination Rule changes.

An insurer covered by the Rule that provides or administers health-related insurance or other health-related coverage:

- Shall not:
  - Cancel, limit or refuse to issue or renew a policy or plan
  - Deny or limit coverage of a claim
  - Apply additional cost sharing

  to a person because of race, color, national origin, sex, age, or disability.

- Shall not:
  - Deny or limit coverage
  - Deny or limit coverage of a claim
  - Apply additional cost sharing

  to a transgender person, if it results in discrimination against that person.

- Shall not exclude or limit health services related to gender transition.

Innovation Health is the brand name used for products and services provided by Innovation Health Insurance Company and/or Innovation Health Plan, Inc. Innovation Health is an affiliate of Inova and Aetna Life Insurance Company and its affiliates. Aetna and its affiliates provide certain management services to Innovation Health. Aetna companies that receive funds from the federal Department of Health and Human Services are subject to the Rule.

NOTICE OF PROTECTION PROVIDED BY
VIRGINIA LIFE, ACCIDENT AND SICKNESS INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** of the Virginia Life, Accident and Sickness Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Virginia law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that a life, annuity or accident and sickness insurance company (including a health maintenance organization) licensed in the Commonwealth of Virginia becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Virginia law, with funding from assessments paid by other life and health insurance companies licensed in the Commonwealth of Virginia.

The basic protections provided by the Association are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender and withdrawal values
- Health Insurance
  - $500,000 for health benefit plans
  - $300,000 in disability income insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of accident and sickness insurance benefits
- Annuities
  - 250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $350,000, except for health benefit plans, for which the limit is increased to $500,000.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Virginia law.

To learn more about the above protections, please visit the Association's website at www.valifega.org or contact:

VIRGINA LIFE, ACCIDENT AND SICKNESS
INSURANCE GUARANTY ASSOCIATION
c/o APM Management Services, Inc.
1503 Santa Rosa Road, Suite 101
Henrico, VA 23229-5105
804-282-2240

STATE CORPORATION COMMISSION
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218-1157
804-371-9741
Toll Free Virginia only: 1-800-552-7945
http://scc.virginia.gov/boi/index.aspx

Insurance companies and agents are not allowed by Virginia law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Virginia law, then Virginia law will control.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network facility, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay, and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

Insurers are required to tell you which providers and facilities are in their networks. Providers and facilities must tell you with which provider networks they participate. This information is on the insurer's, provider's or facility's website or on request.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of- network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as deductibles, copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services at the same facility that you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network facility
When you get services from an in-network facility, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, laboratory, surgeon and assistant surgeon services, and professional ancillary services such as anesthesia, pathology, radiology, neonatology, hospitalist, or intensivist services. These providers **can't** balance bill you and **can't** ask you to give up your protections not to be balance billed.

If you receive other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan'snetwork.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:

    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).

    - Cover emergency services by out-of-network providers.

    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and in-network out-of-pocket limit.

If you believe you've been wrongly billed, you may call the federal agencies responsible for enforcing the federal balance billing protection law at: **1-800-985-3059** and/or file a complaint with the Virginia State Corporation Commission Bureau of Insurance at: scc.virginia.gov/pages/File-Complaint-Consumers or call **1-877-310-6560**.

Visit cms.gov/nosurprises for more information about your rights under federal law.

Consumers covered under (i) a fully-insured policy issued in Virginia, (ii) the Virginia state employee health benefit plan; or (iii) a self-funded group that opted-in to the Virginia protections are also protected from balance billing under Virginia law. Visit scc.virginia.gov/pages/Balance-Billing-Protection for more information about your rights under Virginia law.

Innovation Health Plan, Inc.

Schedule of benefits

If this is an XXXXX plan, you may have certain rights under this plan. XXXXX may not apply to a church or government group. Please contact the contract holder for additional information.

Prepared for:
Contract holder: SAMPLE CO., INC.
Contract holder number: SAMPLE
HMO group agreement effective date: SAMPLE
Plan name: Open Access Health Network Option
Plan effective date: SAMPLE

"**Innovation Health**" is the brand name used for products and services provided by one or more of the Innovation Health group of subsidiary companies.
"**Aetna**" is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies.

Schedule of benefits

This schedule of benefits (schedule) lists the **deductibles**, **copayments** or **coinsurance**, if any apply to the **covered services** you receive under the plan. You should review this schedule to become aware of these and any limits that apply to these services.

How your cost share works

- The **deductibles**, **copayments**/**coinsurance**, if any, listed in the schedule below are the amounts that you pay for **covered services**.
- You are responsible to pay any **deductibles**, **copayments/coinsurance** if they apply and before the plan will pay for any **covered services**.
- This plan doesn't cover every health care service. You pay the full amount of any health care service you get that is not a **covered service**.
- This plan has limits for some **covered services**. For example, these could be visit, day or dollar limits. They may be:
  - Separate limits for in-network and **out-of-network providers**

  See the schedule for more information about limits.
- Your cost share may vary if the **covered service** is preventive or not. Ask your **physician** or contact us if you have a question about what your cost share will be.

For examples of how cost share and **deductible** work, go to the *Using your Innovation Health benefits* section under Individuals & Families at https://www.innovationhealth.com/.

Important note:
Covered services are subject to the contract year **deductible**, **maximum out-of-pocket**, limits, **copayment** or **coinsurance** unless otherwise stated in this schedule.

How your deductible works

The **deductible** is the amount you pay for **covered services** each year before the plan starts to pay. This is in addition to any **copayment** or **coinsurance** you pay when you get **covered services** from an **out-of-network provider**. This schedule shows the **deductible** amounts that apply to your plan. Once you have met your **deductible**, we will start sharing the cost when you get **covered services**. You will continue to pay **copayments** or **coinsurance**, if any, for **covered services** after you meet your **deductible**.

How your PCP or physician office visit cost share works

You will pay the **PCP** cost share when you get **covered services** from any **PCP**.

How your maximum out-of-pocket works

This schedule shows the **maximum out-of-pocket limits** that apply to your plan. Once you reach your **maximum out-of-pocket limit**, your plan will pay for **covered services** for the remainder of that year. We will notify you that you have met your **maximum out-of-pocket limit** no later than 30 days after we have paid enough claims to make that determination. You will not be required to pay cost share for **covered services** for the rest of that year. Any amounts over your **maximum out-of-pocket** will be promptly refunded to you.

Contact us

We are here to answer questions. See the *Contact us* section in your certificate.

Innovation Health Plan, Inc.'s HMO group agreement provides the coverage described in this schedule of benefits. This schedule replaces any schedule of benefits previously in use. Keep it with your certificate.

Plan features

Precertification covered benefit reduction

This only applies to out-of-network **covered services**:
Your certificate contains a complete description of the **precertification** process. You will find details in the *Medical necessity and precertification requirements* section.

If **precertification** for **covered services** isn't completed, when required, it results in the following benefit reduction:

- A 50% **coinsurance** reduction applied separately to the benefit provided for each **covered service**

You may have to pay an additional portion of the **allowable amount** because you didn't get **precertification**. This portion is not a **covered service** and doesn't apply to your **deductible** or **maximum out-of-pocket limit**, if you have one.

Deductible

You have to meet your **deductible** before this plan pays for benefits.

Deductible type	In-network	Out-of-network
Individual	$XXXX per contract year	$ XXXX per contract year
Family	$ XXXX per contract year	$ XXXX per contract year

Maximum out-of-pocket limit

Includes the **deductible**

Maximum out-of-pocket type	In-network	Out-of-network
Individual	$XXXX per contract year	$XXXX per contract year
Family	$XXXX per contract year	$XXXX per contract year

General coverage provisions

This section explains the **deductible**, **maximum out-of-pocket limit** and limitations listed in this schedule.

Deductible provisions

The **deductible** may not apply to some **covered services**. You still pay the **copayment** or **coinsurance**, if any, for these **covered services**.

Individual deductible

You pay for **covered services** each year before the plan begins to pay. This individual **deductible** applies separately to you and each covered dependent. After the amount paid reaches the individual **deductible**, this plan starts to pay for **covered services** for the rest of the year.

Family deductible

You pay for **covered services** each year before the plan begins to pay. After the amount paid for **covered services** reaches this family **deductible**, this plan starts to pay for **covered services** for the rest of the year. To satisfy this family **deductible** for the rest of the year, the combined **covered services** that you and each of your covered dependents incur toward the individual **deductible** must reach this family **deductible** in a year. When this happens in a year, the individual **deductibles** for you and your covered dependents are met for the rest of the year.

Copayment

This is a flat fee you pay for certain visits or **covered services**. A copay can be a dollar amount or percentage. This is in addition to any out-of-pocket costs you have to pay to meet your **deductible**, if you have one.

Coinsurance

This is the percentage of the bill you pay after you meet your **deductible**. This is in addition to any out-of-pocket costs you have to pay to meet your **deductible**, if you have one.

Maximum out-of-pocket limit

The **maximum out-of-pocket limit** is the most you will pay per year in **copayments**, **coinsurance** and **deductible**, if any, for **covered services**.

In-network **covered services** will apply only to the in-network **maximum out-of-pocket limit**. Out-of-network **covered services** will apply only to the out-of-network **maximum out-of-pocket limit**.

Individual maximum out-of-pocket limit

- This plan may have an individual and family **maximum out-of-pocket limit**. As to the individual **maximum out-of-pocket limit**, each of you must meet your **maximum out-of-pocket limit** separately.
- After you or your covered dependents meet the individual **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered services** that would apply toward the limit for the rest of the year for that person.

Family maximum out-of-pocket limit

After you or your covered dependents meet the family **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered services** that would apply toward the limit for the remainder of the year for all covered family members. The family **maximum out-of-pocket limit** is a cumulative **maximum out-of-pocket limit** for all family members.

To satisfy this **maximum out-of-pocket limit** for the rest of the year, the following must happen:

- The family **maximum out-of-pocket limit** is met by a combination of family members
- No one person within a family will contribute more than the individual **maximum out-of-pocket limit** amount in a year

If the **maximum out-of-pocket limit** does not apply to a **covered service**, your cost share for that service will not count toward satisfying the **maximum out-of-pocket limit** amount.

Certain costs that you have do not apply toward the **maximum out-of-pocket limit**. These include:

- All costs for non-covered services which are identified in the certificate and the schedule

Calculation of your contribution

We will apply amounts paid by you or paid by another person on your behalf toward your cost share or **maximum out-of-pocket limit**, if you have one, to the extent as allowed by federal law and regulation.

Limit provisions

Covered services applied to the in-network limit will apply only to the in-network limit. **Covered services** applied to the out-of-network limit will apply only to the out-of-network limit.

Your financial responsibility and decisions regarding benefits

We base your financial responsibility for the cost of services on when the service or supply is provided, not when payment is made. We calculate your **coinsurance**, if any, based on **negotiated charge** and **allowable amount**. See the *How your plan works – What the plan pays and what you pay* section in your certificate for more information. Benefits will be pro-rated to account for treatment or portions of **stays** that occur in more than one year. Decisions regarding when benefits are covered are subject to the terms and conditions of the group agreement.

Covered services

Acupuncture

Description	In-network	Out-of-network
Acupuncture	$XX per visit	XX% per visit
	no **deductible** applies	after **deductible**
Visit limit per year	10	10

Ambulance services

Description	In-network	Out-of-network
Emergency services	$XX per trip	$XX per trip
	no **deductible** applies	no **deductible** applies
Non-emergency services	Not covered	Not covered

Applied behavior analysis

Description	In-network	Out-of-network
Applied behavior analysis	$XX per visit	XX% per visit
	no **deductible** applies	after **deductible**

Autism spectrum disorder

Description	In-network	Out-of-network
Diagnosis and testing	$XX per visit	XX% per visit
	no **deductible** applies	after **deductible**
Treatment	$XX per visit	XX% per visit
	no **deductible** applies	after **deductible**
Occupational (OT), physical (PT) and speech (ST) therapy for autism spectrum disorder	$XX per visit	XX% per visit
	no **deductible** applies	after **deductible**

Important note:
There are no visit limits for any **covered services** to diagnose or treat autism spectrum disorder.

Behavioral health

Mental health disorders treatment

Coverage provided is the same as for any other illness

Description	In-network	Out-of-network
Inpatient services-**room and board** including **residential treatment facility**	$XX per day up to 5 days per admission, then 0% thereafter	XX% per admission
	no **deductible** applies	after **deductible**
Other inpatient services and supplies Other **residential treatment facility** services and supplies	No charge	XX% per admission
Outpatient office visit to a **physician** or **behavioral health provider**	$XX per visit no **deductible** applies	XX% per visit after **deductible**
Outpatient **mental health disorders telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider**	$XX per visit no **deductible** applies	XX% per visit after **deductible**
Physician or **behavioral health provider telemedicine** consultation	$XX per visit no **deductible** applies	XX% per visit after **deductible**
Other outpatient services including: • Behavioral health services in the home • Partial hospitalization treatment • Intensive outpatient program The cost share doesn't apply to in-network peer counseling support services	$XX per visit	XX% per visit
	no **deductible** applies	after **deductible**
Telemedicine provider mental health disorders consultation	Covered based on type of service and **provider** from which it is received	Not covered

Substance use disorders treatment

Includes **detoxification**, rehabilitation and **residential treatment facility**

Coverage provided is the same as for any other illness

Description	In-network	Out-of-network
Inpatient services – **room and board** during a **hospital stay**	$XX per day up to 5 days per admission, then 0%	XX% per admission
	no **deductible** applies	after **deductible**
Other inpatient services and supplies during a **hospital stay**	No charge	XX% per admission
Outpatient office visit to a **physician** or **behavioral health provider**	$XX per visit no **deductible** applies	XX% per visit after **deductible**
Outpatient **telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider**	$XX per visit	XX% per visit
	no **deductible** applies	after **deductible**
Physician or **behavioral health provider telemedicine** consultation	$XX per visit no **deductible** applies	XX% per visit after **deductible**
Other outpatient services including: • Behavioral health services in the home • Partial hospitalization treatment • Intensive outpatient program The cost share doesn't apply to in-network peer counseling support services	$XX per visit	XX% per visit
	no **deductible** applies	after **deductible**
Telemedicine provider substance use disorders consultation	Covered based on type of service and **provider** from which it is received	Not covered

Clinical trials

Description	In-network	Out-of-network
Experimental or investigational therapies	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Routine patient costs	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Dental anesthesia and hospital charges for dental care

Description	In-network	Out-of-network
Performed in a **hospital** or outpatient facility	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Dental injury

Description	In-network	Out-of-network
Dental services to repair natural teeth damaged or lost due to accidental injury	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Diabetic services, supplies, equipment, and self-care programs

Description	In-network	Out-of-network
Diabetic services	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Diabetic supplies	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Diabetic equipment	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Diabetic self-care programs	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Durable medical equipment (DME)

Description	In-network	Out-of-network
DME	$XX per item	XX% per item

	no **deductible** applies	after **deductible**

Emergency services

Description	In-network	Out-of-Network
Emergency room	$XX per visit	Paid same as in-network

	no **deductible** applies	

Non-emergency care in a **hospital** emergency room	$XX per visit	XX% per visit

	after **deductible**	no **deductible** applies

Emergency services important note:
Out-of-network providers do not have a contract with us. The **provider** may not accept payment of your cost share as payment in full. You may receive a bill for the difference between the amount billed by the **provider** and the amount paid by the plan. If the **provider** bills you for an amount above your cost share, you are not responsible for payment of that amount. You should send the bill to the address on your ID card and we will resolve any payment issue with the **provider**. Make sure the member ID is on the bill. If you are admitted to the **hospital** for an inpatient **stay** right after you visit the emergency room, you will not pay your emergency room cost share if you have one. You will pay the inpatient **hospital** cost share, if any.

Habilitation therapy services

Physical (PT), occupational (OT) therapies

Description	In-network	Out-of-network
PT, OT therapies	$XX per visit	XX% per visit

	no **deductible** applies	after **deductible**

Speech therapy

Description	In-network	Out-of-network
ST	$XX per visit	XX% per visit

	no **deductible** applies	after **deductible**

Hemophilia and congenital bleeding disorders

Description	In-network	Out-of-network
Home treatment supervised by a state-approved hemophilia treatment center	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Home health care

A visit is a period of 4 hours or less

Description	In-network	Out-of-network
Home health care	$XX per visit	XX% per visit

	no **deductible** applies	after **deductible**

Visit limit per day	3 intermittent visits	3 intermittent visits
Limit per year	100	100

Home health care important note:
Intermittent visits are periodic and recurring visits that skilled nurses make to ensure your proper care. The intermittent requirement may be waived to allow for coverage for up to 12 hours with a daily maximum of 3 visits.

Hospice care

Description	In-network	Out-of-network
Inpatient services - **room and board**	$XX per admission	XX% per admission
	no **deductible** applies	after **deductible**
Other inpatient services	No charge	0% per admission
Outpatient services	$XX per visit	XX% per visit
	no **deductible** applies	after **deductible**

Hospice important note:
This includes part-time or infrequent nursing care by an R.N. or L.P.N. to care for you up to 8 hours a day. It also includes part-time or infrequent home health aide services to care for you up to 8 hours a day.

Hospital care

Description	In-network	Out-of-network
Inpatient services – **room and board**	$XX per day up to 5 days per admission, then 0% thereafter	XX% per admission
	no **deductible** applies	after **deductible**
Other inpatient services	No charge	XX% per admission

Infertility services

Description	In-network	Out-of-network
Treatment of basic **infertility**	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Jaw joint disorder

Includes TMJ

Description	In-network	Out-of-network
Jaw joint disorder treatment	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Lymphedema

Description	In-network	Out-of-network
Lymphedema	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Maternity and related newborn care

Includes complications

Coverage provided is the same as for any other illness

Description	In-network	Out-of-network
Inpatient services – **room and board**	$XX per day up to 5 days per admission, then 0% thereafter	XX% per admission
	no **deductible** applies	after **deductible**
Other inpatient services	No charge	XX% per admission
Services performed in **physician** or **specialist** office or a facility	$XX per visit	XX% per visit
	no **deductible** applies	after **deductible**
Other services and supplies	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Maternity and related newborn care important note:
Any cost share collected applies only to the delivery and postpartum care services provided by an OB, GYN or OB/GYN. Review the *Maternity* section of the certificate. It will give you more information about coverage for maternity care under this plan.

Nutritional support

Description	In-network	Out-of-network
Formula and enteral nutrition products	XX% per item no **deductible** applies	XX% per item after **deductible**
Equipment, supplies and services	$XX per item	XX% per item
	no **deductible** applies	after **deductible**

Outpatient surgery

Description	In-network	Out-of-network
At **hospital** outpatient department	$XX per visit	XX% per visit
	no **deductible** applies	after **deductible**
At facility that is not a **hospital**	$XX per visit	XX% per visit
	no **deductible** applies	after **deductible**
At the **physician** office	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Physician and specialist services

Including surgical services

Description	In-network	Out-of-network
Physician office hours (not surgical, not preventive)	$XX per visit	XX% per visit
	no **deductible** applies	after **deductible**
Immunizations that are not considered preventive care	Covered based on type of service and where it is received.	Covered based on type of service and where it is received.
Physician visit during inpatient **stay**	$XX per visit	XX% per visit
	no **deductible** applies	after **deductible**
Physician home visit (not preventive)	$XX per visit	XX% per visit
	no **deductible** applies	after **deductible**
Physician surgical services	$XX per visit	XX% per visit

	no **deductible** applies	after **deductible**

Physician telemedicine consultation	$XX per visit no **deductible** applies	XX% per visit after **deductible**

Telemedicine **provider** consultation Basic medical services	Covered based on type of service and **provider** from which it is received	Not covered

Specialist

Description	In-network	Out-of-network
Specialist office hours (not surgical, not preventive)	$XX per visit	XX% per visit
	no **deductible** applies	after **deductible**
Specialist home visit (not preventive)	$XX per visit	XX% per visit
	no **deductible** applies	after **deductible**
Specialist surgical services	$XX per visit	XX% per visit
	no **deductible** applies	after **deductible**
Specialist telemedicine consultation	$XX per visit no **deductible** applies	XX% per visit after **deductible**
Telemedicine **provider** consultation **Specialist** services	Covered based on type of service and **provider** from which it is received	Not covered

Preventive care

Description	In-network
Preventive care services	$XX no **deductible** applies
Breast feeding counseling and support limit	6 visits in a group or individual setting Visits that exceed the limit are covered under the **physician** services office visit
Breast pump, accessories and supplies limit	Electric pump: 1 every 1 year Manual pump: 1 per pregnancy Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump
Breast pump waiting period	Electric pump: 1 year to replace an existing electric pump

Description	In-network
Counseling for alcohol or drug misuse visit limit per day	1
Counseling for alcohol or drug misuse visit limit	5 visits/12 months
Counseling for obesity, healthy diet visit limit per day	1
Counseling for obesity, healthy diet visit limit	Age 0-22: unlimited visits Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.
Counseling for sexually transmitted infection visit limit	2 visits/12 months
Counseling for tobacco cessation visit limit per day	1
Counseling for tobacco cessation visit limit	8 visits/12 months
Family planning services (female contraception and counseling) limit	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting
Immunizations limit	Covered persons age 0-99 Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**
Routine cancer screening limits	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF The comprehensive guidelines supported by the Health Resources and Services Administration For more information contact your **physician** or see the *Contact us* section of your certificate
Routine lung cancer screening limit	1 screening every 12 months Screenings that exceed this limit covered as outpatient diagnostic testing

Description	In-network
Routine physical exam limits	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents Limited to 7 exams from age 0-1 year 3 exams every 12 months age 1-2 3 exams every 12 months age 2-3 and 1 exam every 12 months after that age, up to age 22 1 exam every 12 months after age 22 High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1 every 36 months
Well woman routine GYN exam limit	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration

Prosthetic devices

Includes medical wigs

Description	In-network	Out-of-network
Prosthetic devices	$XX per item	XX% per item
	no **deductible** applies	after **deductible**
Limit per year	unlimited	unlimited

Reconstructive surgery and supplies

Including breast **surgery**

Description	In-network	Out-of-network
Surgery and supplies	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Routine cancer screenings

Description	In-network	Out-of-network
Colonoscopy	$XX per test no **deductible** applies	XX% per test after **deductible**
Digital rectal examination (DRE)	$XX per test no **deductible** applies	XX% per test after **deductible**
Double contrast barium enema (DCBE)	$XX per test no **deductible** applies	XX% per test after **deductible**
Fecal occult blood test (FOBT)	$XX per test no **deductible** applies	XX% per test after **deductible**

Mammogram	$XX per test	XX% per test
	no **deductible** applies	after **deductible**
Prostate specific antigen (PSA) test	$XX per test	XX% per test
	no **deductible** applies	after **deductible**
Sigmoidoscopy	$XX per test	XX% per test
	no **deductible** applies	after **deductible**
Cancer screening limits	• Subject to any age, family history and frequency guidelines as set forth in the most current: – Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF – The comprehensive guidelines supported by the Health Resources and Services Administration • For more information contact your **physician** or see the *Contact us* section of your certificate	• Subject to any age, family history and frequency guidelines as set forth in the most current: – Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF – The comprehensive guidelines supported by the Health Resources and Services Administration • For more information contact your **physician** or see the *Contact us* section of your certificate
Lung cancer screening	$XX per test no **deductible** applies	XX% per test after **deductible**
Limit	• 1 screening every 12 months • Screenings that exceed this limit are covered as outpatient diagnostic testing	• 1 screening every 12 months • Screenings that exceed this limit are covered as outpatient diagnostic testing

Short-term rehabilitation services

Cardiac rehabilitation

Description	In-network	Out-of-network
Cardiac rehabilitation	$XX per visit no **deductible** applies	XX% per visit after **deductible**

Pulmonary rehabilitation

Description	In-network	Out-of-network
Pulmonary rehabilitation	$XX per visit no **deductible** applies	XX% per visit after **deductible**

Cognitive rehabilitation

Description	In-network	Out-of-network
Cognitive rehabilitation	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Physical, occupational and speech therapies

Description	In-network	Out-of-network
At the **physician** office	$XX per visit no **deductible** applies	XX% per visit after **deductible**
At facility that is not a **hospital**	$XX per visit no **deductible** applies	XX% per visit after **deductible**
At **hospital** outpatient department	$XX per visit no **deductible** applies	XX% per visit after **deductible**

Visit limit per day	1	1
Visit limit per year	30	30

Spinal manipulation

Description	In-network	Out-of-network
At the **physician** office	$XX per visit no **deductible** applies	XX% per visit after **deductible**
At facility that is not a **hospital**	$XX per visit no **deductible** applies	XX% per visit after **deductible**
At **hospital** outpatient department	$XX per visit no **deductible** applies	XX% per visit after **deductible**

Visit limit per day	1	1
Visit limit per year	30	30

Rehabilitation services important note:
A visit is equal to no more than 1 hour of therapy.

Skilled nursing facility

Description	In-network	Out-of-network
Inpatient services – **room and board**	$XX per day up to 5 days per admission, then 100% (waived if you are transferred from a **hospital** to a **skilled nursing facility**, and the maximum has been satisfied in the **hospital**)	XX% per admission

	no **deductible** applies	after **deductible**

Day limit per year	unlimited	150

Other inpatient services and supplies	No charge	0% per admission

Tests, images and labs - outpatient

Diagnostic complex imaging services

Description	In-network	Out-of-network
At facility that is not a **hospital**	$XX per visit	XX% per visit
	no **deductible** applies	after **deductible**
At **hospital** outpatient department	$XX per visit	XX% per visit
	no **deductible** applies	after **deductible**

Diagnostic lab work

Description	In-network	Out-of-network
At facility that is not a **hospital**	$XX per visit	XX% per visit
	no **deductible** applies	after **deductible**
At **hospital** outpatient department	$XX per visit	XX% per visit
	no **deductible** applies	after **deductible**

Diagnostic x-ray and other radiological services

Description	In-network	Out-of-network
At facility that is not a **hospital**	$XX per visit	XX% per visit
	no **deductible** applies	after **deductible**
At **hospital** outpatient department	$XX per visit	XX% per visit
	no **deductible** applies	after **deductible**

Therapies

Chemotherapy

Description	In-network	Out-of-network
Chemotherapy services	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Gene-based, cellular and other innovative therapies (GCIT)

Description	In-network (GCIT-designated facility/provider)	Out-of-network (Including **providers** who are otherwise part of Aetna's network but are not GCIT-designated facilities/**providers**)
Services and supplies	Covered based on type of service and where it is received	Not covered

Infusion therapy

Outpatient services

Description	In-network	Out-of-network
In **physician** office	$XX per visit	XX% per visit
	no **deductible** applies	after **deductible**
At an infusion location	$XX per visit	XX% per visit
	no **deductible** applies	after **deductible**
In the home	$XX per visit	XX% per visit
	no **deductible** applies	after **deductible**
At **hospital** outpatient department	$XX per visit	XX% per visit
	no **deductible** applies	after **deductible**
At facility that is not a **hospital**	$XX per visit	XX% per visit
	no **deductible** applies	after **deductible**

Radiation therapy

Description	In-network	Out-of-network
Radiation therapy	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Transplant services

Description	Network (IOE facility)	Out-of-network (Including **providers** who are otherwise part of Aetna's network but are non-IOE **providers**)
Inpatient services and supplies	$XX per day up to 5 days per admission, then 0% thereafter	XX% per admission
	no **deductible** applies	after **deductible**

Urgent care services

At a freestanding facility or **provider** that is not a **hospital**

A separate urgent care cost share will apply for each visit to an urgent care facility or **provider**

Description	In-network	Out-of-network
Urgent care facility	$XX per visit	XX% per visit
	no **deductible** applies	after **deductible**
Complex imaging, lab and radiology services	No charge	$XX per visit
Non-urgent use of an urgent care facility or **provider**	Not covered	Not covered

Vision care

Performed by an ophthalmologist or optometrist and includes refraction

Adult vision care

Description	In-network	Out-of-network
Adult vision exam	$XX per visit	XX% per visit
	no **deductible** applies	after **deductible**
Limit	Limited to covered persons age 19 and older	Limited to covered persons age 19 and older
Visit limit	1 every 12 months	1 every 12 months

Pediatric vision care

Description	In-network	Out-of-network
Pediatric vision exam	$XX per visit	XX% per visit
	no **deductible** applies	after **deductible**
Limit	Limited to covered persons through the end of the month in which the person turns 19	Limited to covered persons through the end of the month in which the person turns 19
Visit limit	1 every 12 months	1 every 12 months

Walk-in clinic

Not all preventive care services are available at a **walk-in clinic**. All services are available from a network **physician**.

Description	Designated network	Non-designated network	Out-of-network
Non-emergency services	$XX per visit	$XX per visit	XX% per visit
	no **deductible** applies	no **deductible** applies	after **deductible**
Telemedicine consultation for non-emergency services through a **walk-in clinic**	$XX per visit no **deductible** applies	Not covered	Not covered
Preventive care immunizations	$XX per visit	$XX per visit	XX% per visit
	no **deductible** applies	no **deductible** applies	after **deductible**
Immunization limits	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician.**	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician.**	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician.**
Preventive screening and counseling services	$XX per visit no **deductible** applies	$XX per visit no **deductible** applies	Not covered
Telemedicine consultation for preventive screening and counseling services through a **walk-in clinic**	$XX per visit no **deductible** applies	Not covered	Not covered
Preventive screening and counseling limits	See the *Preventive care* section of the schedule	See the *Preventive care* section of the schedule	Not covered

Important note:
Key terms
Designated network provider
A **network provider** listed in the directory under *Best results for your plan* as a **provider** for your plan.

Non-designated network provider
A **provider** listed in the directory under the *All other results* tab as a **provide**r for your plan.
See the *Contact us* section if you have questions

You will pay less cost share when you use a designated network **walk-in clinic provider**. Non-designated network **walk-in clinic providers** are available to you, but the cost share will be at a higher level when these **providers** are used.