INNOVATION HEALTH INSURANCE COMPANY

Exclusive provider organization (EPO) medical plan

Certificate of coverage

Prepared for:

Policyholder:	SAMPLE
Policyholder number:	GP-SAMPLE
Plan name:	Innovation Health Open Access Elect Choice EPO
Booklet-certificate:	
Group policy effective date:	JANUARY 1, 2023
Plan effective date:	JANUARY 1, 2023
Plan issue date:	JANUARY 1, 2023

Underwritten by Innovation Health Insurance Company
3190 Fairview Park Drive, 5th floor, Suite 570,
Falls Church, VA 22042

This certificate of coverage is made part of the group policy

AL HCOC 09 as amended by
AL COCAmend-2022 01

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-855-337-2212.

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 1-855-337-2212.

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 1-855-337-2212.

Para acceder a los servicios de idiomas sin costo, llame al 1-855-337-2212. (Spanish)

如欲使用免費語言服務，請致電 1-855-337-2212。(Chinese)

Afin d'accéder aux services langagiers sans frais, composez le 1-855-337-2212. (French)

Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-855-337-2212. (Tagalog)

T'áá ni nizaad k'ehjí bee níká a'doowoł doo bą́ąh ílínígóó kojį' hólne' 1-855-337-2212. (Navajo)

Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-855-337-2212 an. (German)

Për shërbime përkthimi falas për ju, telefononi 1-855-337-2212. (Albanian)

የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-855-337-2212 ይደውሉ። (Amharic)

للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1-855-337-2212. (Arabic)

Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-855-337-2212 հեռախոսահամարով: (Armenian)

Kugira uronke serivisi z'indimi atakiguzi, hamagara 1-855-337-2212 (Bantu)

আপনাকে বিনামূল্যে ভাষা পরিষেবা পেতে হলে এই নম্বরে টেলিফোন করুন: 1-855-337-2212। (Bengali)

Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-855-337-2212. (Bisayan-Visayan)

သင့်အနေဖြင့် အခကြေးငွေ မပေးရပဲ ဘာသာစကားဝန်ဆောင်မှုများ ရရှိနိုင်ရန် 1-855-337-2212 သို့ ဖုန်းခေါ်ဆိုပါ။ (Burmese)

Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-855-337-2212. (Catalan)

Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-855-337-2212. (Chamorro)

ᏩᎩᏍᏗ ᏚᏪᏂᎯᏍᏗ ᎤᏳᎾᏓᏛᏁᏗ Ꮭ ᎪᎱᏍᏗ ᏗᎬᎨᏔᏁᏗ ᏍᏉ, ᏫᏥᎯᏓᏔᏛᏓ 1-855-337-2212. (Cherokee)

Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-855-337-2212. (Choctaw)

Tajaajiiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-855-337-2212. (Cushite-Oromo)

Voor gratis toegang tot taaldiensten, bell 1-855-337-2212. (Dutch)

Pou jwenn sèvis lang gratis, rele 1-855-337-2212. (French Creole-Haitian)

Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-855-337-2212. (Greek)

તમારે કોઇ જાતના ખર્ચ વિના ભાષાની સેવાઓની પહોંચ માટે, કોલ કરો 1-855-337-2212. (Gujarati)

No ka wala‘au ‘ana me ka lawelawe ‘ōlelo e kahea aku i kēia helu kelepona 1-855-337-2212. Kāki ‘ole ‘ia kēia kōkua nei. (Hawaiian)

आपके लिए बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, 1-855-337-2212 पर कॉल करें। (Hindi)

Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-855-337-2212. (Hmong)

Iji nwetaòhèrè na ọrụ gasị asụsụ n'efu, kpọọ 1-855-337-2212. (Ibo)

Tapno maaksesyo dagiti serbisio maipapan iti pagsasao nga awan ti bayadanyo, tawagan ti 1-855-337-2212. (Ilocano)

Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi 1-855-337-2212. (Indonesian)

Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-855-337-2212 (Italian)

言語サービスを無料でご利用いただくには、1-855-337-2212までお電話ください。(Japanese)

လာတက်ကမၤနှၤ်ကျိာ်အတၢ်မၤစၢၤအတၢ်ဖံးတၢ်မၤတဖျဲလၢတအိာ်ဒီးအပူၤလၢကဘဉ်ဟုာ်အီၤအဂီၢ်ဘဉ်နုဉ် ကိး: 1-855-337-2212 တက့ၢ်. (Karen)

무료 언어 서비스를 이용하려면 1-855-337-2212번으로 전화해 주십시오. (Korean)

Ǹ dyi wuɖu-dù kà kò ɖò ɓě dyi mɔ́uń nì Pídyi ní, nìí, ɖá nɔ̀ɓà nìà kɛ: 1-855-337-2212. (Kru-Bassa)

بۆ دەستپێڕاگەیشتن بە خزمەتگوزاری زمان بەبێ تێچوون بۆ تۆ، پەیوەندی بکە بە ژمارەی 1-855-337-2212. (Kurdish)

ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໂທຫາເບີ 1-855-337-2212. (Laotian)

कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-855-337-2212 वर फोन करा. (Marathi)

Nan etal nan jikin jiban ikijen Kajin ilo an ejelok onen nan kwe, kirlok 1-855-337-2212. (Marshallese)

Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih 1-855-337-2212. (Micronesian-Pohnpeian)

ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-855-337-2212។ (Mon-Khmer, Cambodian)

निःशुल्क भाषा सेवा प्राप्त गर्न 1-855-337-2212 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 1-855-337-2212. (Nilotic-Dinka)

For tilgang til kostnadsfri språktjenester, ring 1-855-337-2212. (Norwegian)

Um Schprooch Services zu griege mitaus Koscht, ruff 1-855-337-2212. (Pennsylvania Dutch)

برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-855-337-2212 تماس بگیرید. (Persian-Farsi)

Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-855-337-2212 (Polish)

Para acessar os serviços de idiomas sem custo para você, ligue para 1-855-337-2212. (Portuguese)

ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, 1-855-337-2212 ‘ਤੇ ਫ਼ੋਨ ਕਰੋ। (Punjabi)

Pentru a accesa gratuit serviciile de limbă, apelați 1-855-337-2212. (Romanian)

Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-855-337-2212. (Russian)

Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala’au le 1-855-337-2212. (Samoan)

Za besplatne prevodilačke usluge pozovite 1-855-337-2212. (Serbo-Croatian)

Heeba a nasta jangirde djey wolde wola chede bo apelou lamba 1-855-337-2212. (Sudanic-Fulfulde)

Kupata huduma za lugha bila malipo kwako, piga 1-855-337-2212. (Swahili)

[illegible]

(Syriac-Assyrian) 1-855-337-2212

మీరు భాష సేవలను ఉచితంగా అందుకునేందుకు, 1-855-337-2212కు కాల్ చేయండి. (Telugu)

หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-855-337-2212 (Thai)

Kapau ‘oku ke fiema’u ta’etōtōngi ‘a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he 1-855-337-2212. (Tongan)

Ren omw kopwe angei aninisin eman chon awewei (ese kamo), kopwe kori 1-855-337-2212. (Trukese)

Sizin için ücretsiz dil hizmetlerine erişebilmek için, 1-855-337-2212 numarayı arayın. (Turkish)

Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-855-337-2212. (Ukrainian)

بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-855-337-2212. پر بات کریں۔ (Urdu)

Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-855-337-2212. (Vietnamese)

צו צוטריט שפראַך באַדינונגען אין קיין פּריַז צו איר, רופן 1-855-337-2212. (Yiddish)

Lati wọnú awọn isẹ èdè l’ọfẹ fun ọ, pe 1-855-337-2212. (Yoruba)

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Welcome

At Innovation Health, your health goals lead the way, so we're joining you to put them first. We believe that whatever you decide to do for your health, you can do it with the right support. And no matter where you are on this personal journey, it's our job to enable you to feel the joy of achieving your best health.

Welcome to Innovation Health.

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 policy, they describe your Innovation Health plan. Each may have amendments attached to them. These change or add to the document. This certificate takes the place of any others sent to you before.

It's really important that you read the entire certificate and your schedule of benefits.

If your coverage under any part of this plan replaces coverage under another plan, your coverage for benefits provided under the other coverage may reduce benefits paid by this plan. See the *Coordination of benefits, Effect of prior plan coverage* section.

We are regulated in Virginia by both the State Corporation Commission Bureau of Insurance under Title 38.2 of the Code of Virginia and the Virginia Department of Health under Title 32.1 of the Code of Virginia.

If you need help or 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 Insurance Company
- Words that are in bold, we define them in the *Glossary* section

Contact us – important information regarding your insurance

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

- Calling the toll-free number on your ID card
- Logging in to the Innovation Health website at https://www.innovationhealth.com/
- Writing us at 3190 Fairview Park Drive, 5th floor, Suite 570, Falls Church, VA 22042

Your 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 so that a record of your inquiry is maintained. When contacting us, the agent or the BOI, have your policy number available.

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 your member 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, 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 Aetna 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

Discount arrangements

We can offer you discounts on health care related goods or services. Sometimes, other companies provide these discounted goods and services. These companies are called "third party service providers". These third party service providers may pay us so that they can offer you their services.

Third party service providers are independent contractors. The third party service provider is responsible for the goods and services they deliver. We have the right to change or end the arrangements at any time.

These discount arrangements are not insurance. We don't pay the third party service providers for the services they offer. You are responsible for paying for their services and discounted goods.

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.

For **covered services** under the outpatient **prescription** drug plan:

- You need a **prescription** from the prescribing **provider**
- You need to show your ID card to the **network pharmacy** when you get a **prescription** filled

This plan provides insurance 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.
- Your **provider** may recommend services that are considered **experimental or investigational** services. But an **experimental or investigational** service is not covered and is also an exclusion, unless it is recognized as part of an approved clinical trial when you have cancer or a **terminal illness**. See *Clinical trials* in the list of services below.
- 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 behavior analysis means the design, implementation and evaluation of environmental changes by applying interventions using behavioral stimuli and consequences that:

- Systematically change behavior
- Are responsible for observable improvements in behavior, including the use of:
  - Direct observation
  - Measurement
  - Functional analysis of the relationship between environment and behavior

Autism spectrum disorder

Autism spectrum disorder is a mental health condition as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association.

Covered services include services and supplies provided by a **physician** or **behavioral health provider** for:

- The diagnosis and treatment of autism spectrum disorder
- Physical, occupational, and speech therapy associated with the diagnosis of autism spectrum disorder

We will cover treatment ordered by a **physician** or **behavioral health provider** as part of a treatment plan they develop:

- Following a complete evaluation or re-evaluation
- In accordance with the most recent clinical report or recommendation on 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

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 includes 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**.

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.

Coverage is limited to benefits for routine patient services provided within the network.

“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 or 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 (FDA), or is a drug that is exempt from having an investigational new drug application

Dental anesthesia

Covered services include anesthesia and hospitalization or outpatient 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 7 years of age.

For purposes of this review, a determination of **medical necessity** includes but is not 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.

Diabetic services, supplies, equipment, and self-care programs

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
- Prescribed self-care programs with a health care **provider** certified in diabetes self-care training, including medical nutrition therapy

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

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 must 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

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

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**

Hemophilia and congenital bleeding disorders

Covered services for home treatment of routine bleeding episodes associated with hemophilia and other congenital 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, 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

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, 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, outpatient or home basis
- Services by a hospice care agency or hospice care provided in a **hospital**
- Psychological, psychosocial and dietary counseling
- Pain management and symptom control
- Bereavement counseling
- Respite and palliative care

Hospice care services provided by the **providers** below will be covered, even if the **providers** are not an

employee of the hospice care agency responsible for your care:

- A **physician** for consultation or case management
- A physical or occupational therapist
- A **home health care agency** for:
  - Physical and occupational therapy
  - Medical supplies
  - Outpatient **prescription** drugs
  - Psychological and psychosocial counseling
  - Dietary counseling

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**.
- 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 the *Hemophilia and congenital bleeding disorders* section 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.

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

Basic infertility

Covered services include seeing a **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 ovulation induction cycle while on injectable medication to stimulate the ovaries. This includes, but is not limited to, imaging, laboratory services, and professional services.
- Artificial insemination services.

Jaw joint disorder treatment

Covered services include the diagnosis, surgical and non-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)

Lymphedema

Covered services include the diagnosis, evaluation and treatment of lymphedema. Your plan will cover:

- 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

If the mother is discharged earlier, the plan will pay for home visits after delivery by a health care **provider** according to the guidelines recommended by the American Academy of Pediatrics or the American College of Obstetricians and Gynecologists. **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

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

Oral and maxillofacial treatment (mouth, jaws and teeth)

Covered services include the following when provided by a **physician**, dentist and **hospital**:

- Cutting out:
  - Teeth partly or completely impacted in the bone of the jaw
  - Teeth that will not erupt through the gum
  - Other teeth that cannot be removed without cutting into bone
  - The roots of a tooth without removing the entire tooth
  - Cysts, tumors, or other diseased tissues
- Cutting into gums and tissues of the mouth:
  - Only when not associated with the removal, replacement or repair of teeth

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)
- 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**

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.

Telemedicine may have a different cost share from other **physician** services. See your schedule of benefits.

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

Prescription drugs - outpatient

Read this section carefully. This plan does not cover all **prescription** drugs and some coverage may be limited. This doesn't mean you can't get **prescription** drugs that aren't covered; you can, but you have to pay for them yourself. For more information about **prescription** drug benefits, including limits, see the schedule of benefits.

Important note:
A pharmacy may refuse to fill or refill a **prescription** when, in the professional judgement of the pharmacist, it should not be filled or refilled.

Your plan provides standard safety checks to encourage safe and appropriate use of medications. These checks are intended to avoid adverse events and align with the medication's FDA-approved prescribing information and current published clinical guidelines and treatment standards. These checks are routinely updated as new medications come to market and as guidelines and standards are updated.

Covered services are based on the drugs in the **drug guide**. We exclude **prescription** drugs listed on the **formulary exclusions list** unless we approve a medical exception. If it is **medically necessary** for you to use a **prescription** drug that is not on this **drug guide**, you or your **provider** must request a medical exception. See *the Requesting a medical exception* section or just contact us.

Your **provider** can give you a **prescription** in different ways including:

- A written **prescription** that you take to a **network pharmacy**
- Calling or e-mailing a **prescription** to a **network pharmacy**
- Submitting the **prescription** to a **network pharmacy** electronically

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 **network 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.

How to access network pharmacies

You can find a **network pharmacy** either online or by phone. See the *Contact us* section for how**.**

You may go to any of our **network pharmacies**. If you don't get your **prescriptions** at a selected pharmacy, your **prescriptions** will not be a **covered service** under the plan. Pharmacies include network **retail**, **mail order** and **specialty pharmacies**.

Some **prescription** drugs are subject to quantity limits. This helps your **provider** and pharmacy ensure your **prescription** drug is being used correctly and safely. We rely on medical guidelines, FDA-approved recommendations and other criteria developed by us to set these limits.

Any **prescription** drug made to work beyond one month shall require the **copayment** amount that equals the expected duration of the medication.

The pharmacy may substitute a **generic prescription drug** for a **brand-name prescription drug**. Your cost share may be less if you use a **generic drug** when it is available.

Pharmacy types

Retail pharmacy

A **retail pharmacy** may be used for up to a 90 day supply of **prescription** drugs. A network **retail pharmacy** will submit your claim. You will pay your cost share directly to the pharmacy. There are no claim forms to complete or submit.

Mail order pharmacy

The drugs available through mail order are maintenance drugs that you take on a regular basis for a chronic or long-term medical condition. Each **prescription** and refill is limited to a maximum 90 day supply.

Prescription refills after the initial fill can be filled at a network **mail order pharmacy**.

Specialty pharmacy

We cover **specialty prescription drugs** when filled through a network **retail** or **specialty pharmacy**.
Each **prescription** is limited to a maximum 30 day supply. You can view the list of **specialty prescription drugs**.
See the *Contact us* section for how.

All **specialty prescription drug** fills including the initial fill must be filled at a network **specialty pharmacy** unless it is an urgent situation.

Prescription drugs covered by this plan are subject to misuse, waste, or abuse utilization review by us, your **provider**, and/or your **network pharmacy**. The outcome of this review may include:

- Limiting coverage of a drug to one prescribing **provider** or one **network pharmacy**
- Quantity, dosage or day supply limits
- Requiring a partial fill or denial of coverage

What if the pharmacy you use leaves the network

Sometimes a pharmacy might leave the network. If this happens, you will have to get your **prescriptions** filled at another **network pharmacy**. You can use your **provider** directory or call us to find another **network pharmacy** in your area.

How to get an emergency prescription filled

You may not have access to a **network pharmacy** in an emergency or urgent situation or you may be traveling outside of your plan's service area. If you must fill a **prescription** in any of these situations, we will reimburse you as shown in the table below:

Type of pharmacy	Your cost share is
A **network pharmacy**	The plan cost share
Out-of-network pharmacy	The full cost of the **prescription**

When you pay the full cost of the **prescription** at an out-of-network pharmacy:

- You will fill out and send a **prescription** drug refund form to us, including all itemized pharmacy receipts
- Coverage will be limited to items obtained in connection with the out-of-area emergency or urgent situation
- Submission of the refund form doesn't guarantee a refund. If approved, you will be reimbursed the cost of the **prescription** less your network cost share

Other covered services

Anti-cancer drugs taken by mouth, including chemotherapy drugs

Covered services include any drug prescribed for cancer treatment. The drug must be recognized for treating cancer in standard reference materials or medical literature even if it isn't approved by the FDA for this treatment.

Contraceptives (birth control)

For females who are able to reproduce, **covered services** include any drugs and devices that the Food and Drug Administration (FDA) has approved to prevent pregnancy. You will need a **prescription** from your **provider** and must fill it at a **network pharmacy**. At least one form of each FDA-approved contraception method is a **covered service**. You can access a list of covered drugs and devices. See the *Contact us* section for how.

We also cover over-the-counter (OTC) and **generic prescription drugs** and devices for each method of birth control approved by the FDA at no cost to you. If a generic drug or device is not available for a certain method, we will cover the **brand-name prescription drug** or device at no cost share.

Preventive contraceptives important note:
You may qualify for a medical exception if your **provider** determines that the contraceptives covered as preventive **covered services** under the plan are not medically appropriate for you. Your **provider** may request a medical exception and submit it to us for review.

Diabetic supplies

Covered services include but are not limited to the following:

- Alcohol swabs
- Blood glucose calibration liquid
- Diabetic syringes, needles and pens
- Continuous glucose monitors
- Insulin infusion disposable pumps
- Lancet devices and kits
- Test strips for blood glucose, ketones, urine

See the *Diabetic services, supplies, equipment, and self-care programs* section for medical **covered services**.

Immunizations
Covered services include preventive immunizations as required by the ACA when given by a **network pharmacy**. You can find a participating **network pharmacy** by contacting us. Check with the pharmacy before you go to make sure the vaccine you need is in stock. Not all pharmacies carry all vaccines.

Infertility drugs
Covered services include synthetic ovulation stimulant **prescription** drugs used to treat the underlying medical cause of **infertility**.

Off-label use
U.S. Food and Drug Administration (FDA) approved **prescription** drugs may be covered when the off-label use of the drug has not been approved by the FDA for your condition. 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.

OTC drugs
Covered services include certain OTC medications when you have a **prescription** from your **provider**. You can see a list of covered OTC drugs by logging on to the Innovation Health website.

Preventive care drugs and supplements
Covered services include preventive care drugs and supplements, including OTC ones, as required by the ACA.

Risk reducing breast cancer prescription drugs
Covered services include **prescription** drugs used to treat people who are at:

- Increased risk for breast cancer
- Low risk for medication side effects

Tobacco cessation prescription and OTC drugs
Covered services include FDA approved **prescription** and OTC drugs to help stop the use of tobacco products. You must receive a **prescription** from your **provider** and submit the **prescription** to the pharmacy for processing.

The following are not **covered services**:

- Abortion drugs
- Allergy sera and extracts given by injection
- Any services related to providing, injecting or application of a drug
- Compounded **prescriptions** containing bulk chemicals not approved by the FDA including compounded bioidentical hormones
- Cosmetic drugs including medication and preparations used for cosmetic purposes
- Devices, products and appliances unless listed as a **covered service**
- Dietary supplements including medical foods
- Drugs or medications
  - Administered or entirely consumed at the time and place it is prescribed or provided

  - Which do not require a **prescription** by law, even if a **prescription** is written, unless we have approved a medical exception
  - That include the same active ingredient or a modified version of an active ingredient as a covered **prescription** drug unless we approve a medical exception
  - That is therapeutically the same or an alternative to a covered **prescription** drug, unless we approve a medical exception
  - That is therapeutically the same or an alternative to an OTC drug unless we have approved a medical exception
  - Not approved by the FDA or not proven safe or effective
  - Provided under your medical plan while inpatient at a healthcare facility
  - That include vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
  - That are used to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity or alter the shape or appearance of a sex organ unless listed as a **covered service**
  - That are used for the purpose of weight gain or loss including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants or other medications
  - That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature unless there is evidence that the member meets one or more clinical criteria detailed in our **precertification** and clinical policies
- Duplicative drug therapy; for example, two antihistamines for the same condition
- Genetic care including:
  - Any treatment, device, drug, service or supply to alter the body's genes, genetic makeup or the expression of the body's genes
- Immunizations related to travel or work
- Immunization or immunological agents except as specifically stated in the schedule of benefits or the certificate
- Implantable drugs and associated devices except as specifically stated in the schedule of benefits or the certificate
- **Infertility**:
  - Injectable **prescription** drugs used primarily for the treatment of **infertility**
- Injectables including:
  - Any charges for the administration or injection of **prescription** drugs
  - Needles and syringes except for those used for insulin administration
  - Any drug which, due to its characteristics as determined by us, must typically be administered or supervised by a qualified **provider** or licensed certified **health professional** in an outpatient setting with the exception of Depo Provera and other injectable drugs for contraception
- Off-label drug use except for indications recognized through peer-reviewed medical literature
- **Prescription** drugs:
  - That are ordered by a dentist or prescribed by an oral surgeon in relation to the removal of teeth or **prescription** drugs for the treatment to a dental condition
  - That are considered oral dental preparations and fluoride rinses except pediatric fluoride tablets or drops as specified on the plan's **drug guide**
  - That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, the use of or intended use of which is illegal, unethical, imprudent, abusive, not **medically necessary** or otherwise improper and drugs obtained for use by anyone other than the member as identified on the ID card
- Replacement of lost or stolen **prescriptions**
- Test agents except diabetic test agents

- Tobacco cessation drugs, unless recommended by the USPSTF
- We reserve the right to exclude:
  - A manufacturer's product when the same or similar drug (one with the same active ingredient or same therapeutic effect), supply or equipment is on the plan's **drug guide**
  - Any dosage or form of a drug when the same drug is available in a different dosage or form on the plan's **drug guide**

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 direct 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, as recommended by the American College of Gastroenterology in association with the American Cancer Society
- Digital rectal exams (DRE)
- Double contrast barium enemas (DCBE)
- Fecal occult blood tests (FOBT), as recommended by the American College of Gastroenterology in association with the American Cancer Society
- Lung cancer screenings
- Mammograms
  - One mammogram if you are age 35 through 39
  - One mammogram every 2 years if you are age 40 through 49
  - One mammogram per year if you are age 50 or older
- Prostate specific antigen (PSA) tests per year if you are either
  - Younger than age 50 but considered to be at high risk
  - Age 50 or older
- Sigmoidoscopies, as recommended by the American College of Gastroenterology in association with the American Cancer Society
- Radiologic imaging in appropriate circumstances for colorectal cancer screening, as recommended by the American College of Gastroenterology in association with the American Cancer Society

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

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

Private duty nursing - outpatient

Covered services include private duty nursing care, ordered by a **physician** and provided by an R.N. or L.P.N. when:

- You are homebound
- Your **physician** orders services as part of a written treatment plan
- Services take the place of a **hospital** or **skilled nursing facility stay**
- Your condition is serious, unstable, and requires continuous skilled 1-on-1 nursing care
- Periodic skilled nursing visits are not adequate

The following are not **covered services**:

- Inpatient private duty nursing care
- Care provided outside the home
- Maintenance or custodial care
- Care for your convenience or the convenience of the family caregiver

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 components, fittings, 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

Component means the materials and equipment needed to ensure the comfort and functioning of a prosthetic device.

You may receive a prosthetic device as part of another **covered service** and therefore it will not be covered under this benefit.

The following are not **covered services**:

- 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 [**physician**] 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 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, including but not limited to cleft lip and 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 facial disfigurement or 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

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 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 birth defect

  (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

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 are not **covered services**:

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

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**

Tests, images and labs - 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
- Other imaging service where the billed charge exceeds $500

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, GCIT, 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**.

Gene-based, cellular and other innovative therapies (GCIT)

Covered services include GCIT provided by a **physician**, **hospital** or other **provider**.

Key Terms

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

Gene

A gene is a unit of heredity which is transferred from a parent to child and is thought to determine some feature of the child.

Molecular

Molecular means relating to or consisting of molecules. A molecule is a group of atoms bonded together, making the smallest vital unit of a chemical compound that can take part in a chemical reaction.

Therapeutic

Therapeutic means a treatment, therapy, or drug meant to have a good effect on the body or mind; adding to a sense of well-being.

GCIT are defined as any services that are:

- Gene-based
- Cellular and innovative therapeutics

The services have a basis in genetic/molecular medicine and are not covered under the Institutes of Excellence™ (IOE) programs. We call these "GCIT services."

GCIT **covered services** include:

- Cellular immunotherapies.
- Genetically modified viral therapy.
- Other types of cells and tissues from and for use by the same person (autologous) and cells and tissues from one person for use by another person (allogenic) for treatment of certain conditions.
- All human gene-based therapy that seeks to change the usual function of a gene or alter the biologic properties of living cells for therapeutic use. Examples include therapies using:
  - Luxturna® (Voretigene neparvovec)
  - Zolgensma® (Onasemnogene abeparvovec-xioi)
  - Spinraza® (Nusinersen)
- Products derived from gene editing technologies, including CRISPR-Cas9.
- Oligonucleotide-based therapies. Examples include:
  - Antisense. An example is Spinraza (Nusinersen).
  - siRNA.
  - mRNA.
  - microRNA therapies.

Facilities/providers for gene-based, cellular and other innovative therapies
We designate facilities to provide GCIT services or procedures. GCIT **physicians**, **hospitals** and other **providers** are GCIT-designated facilities/**providers** for Aetna and CVS Health.

Important note:
You must get GCIT **covered services** from a GCIT-designated facility/**provider**. If there are no GCIT-designated facilities/**providers** assigned 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 GCIT services at the facility/**provider** we designate, they will not be **covered services**.

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 benefit. 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
- Thymus tissue for FDA-approved treatments

Covered services also include:

- Travel and lodging expenses
  - If you are working with an Institutes of Excellence™ (IOE) facility that is 100 or more miles away from where you live, travel and lodging expenses are **covered services** for you and a companion, to travel between home and the IOE facility
  - Coach class air fare, train or bus travel are examples of **covered services**

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

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 need care for an **urgent condition**, you should first seek care through your **physician**, **PCP**. If your **physician**, **PCP** is not reasonably available to provide services, you may access urgent care from an urgent care facility.

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 network (in-network)
  - 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 that is in-network.
- **Urgent condition** outside the network (out-of-network)
  - You are covered for urgent care obtained from a facility that is out-of-network if you are temporarily unable to get services in-network and getting the health care service cannot be delayed.

The following are not **covered services**:

- Non-urgent care in an urgent care center

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, 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

General plan exclusions

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

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. Therapy by a licensed counselor will be covered if provided on an outpatient basis as part of a wilderness treatment program.
- 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, except as described in the *Coverage and exclusions, Early intervention services* section
- Specific developmental disorders of speech and language, except as described in the *Coverage and exclusions, Early intervention services* section
- Other disorders of psychological development

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 apply:

- If services are **medically necessary** and you incur a change for the expense
- For treatment of hemophilia and 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

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

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

Dental services

The following are not **covered services**:

- Services normally covered under a dental plan
- Dental implants

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

Routine services and supplies for the following:

- Routine pedicure services, such as routine cutting of nails, when there is no illness or injury in the nails
- Supplies (including orthopedic shoes), ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies
- Treatment of calluses, bunions, toenails, hammertoes or fallen arches
- Treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working, or wearing shoes

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

Gene-based, cellular and other innovative therapies (GCIT)

The following are not **covered services** unless you receive prior written approval from us:

- GCIT services received at a facility or with a **provider** that is not a GCIT-designated facility/**provider**.
- All associated services when GCIT services are not covered. Examples include:
  - Infusion
  - Lab
  - Radiology
  - Anesthesia
  - Nursing services

See the *How your plan works – Medical necessity and precertification requirements* section.

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

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

Prescription or non-prescription drugs and medicines - outpatient

- Outpatient **prescription** or non-**prescription drugs** and medicines provided by the policyholder or through a third party vendor contract with the policyholder
- Drugs that are included on the list of **specialty prescription drugs** as covered under your outpatient **prescription drug** plan

Routine exams

Routine physical exams, routine eye exams, routine dental exams, routine hearing exams and other preventive services and supplies, except as specifically provided in the *Coverage and exclusions* section

Services provided by a family member

Services provided by a spouse, domestic partner, parent, child, stepchild, 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

Therapies and tests

- Full body CT scans, unless **medically necessary**
- Hair analysis
- Hypnosis and hypnotherapy
- Massage therapy, except when used for physical therapy treatment
- Sensory or hearing and sound integration therapy

Tobacco cessation

Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including, medications, nicotine patches and gum unless recommended by the United States Preventive Services Task Force (USPSTF). This also includes:

- Counseling, except as specifically provided in the *Covered services and exclusions* section
- Hypnosis and other therapies
- Medications, except as specifically provided in the *Covered services and exclusions* section
- Nicotine patches
- Gum

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 medical 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 by logging in to your member website. There you'll find our online **provider** directory. There you'll find our online **provider** directory. You can also call the toll-free number on your member ID card to obtain the information or request a printed directory. See the *Contact us* section for more information.

You choose a network **PCP** to oversee your care. Your **PCP** will provide routine care and send you to other **providers** when you need specialized care. Your plan may 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 transplant services.
See the *Who provides the care* section below.

How your medical 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 Aetna network and from **network providers** without a **PCP referral**
- 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

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 includes treatment for disability, and life-threatening and terminal illness. This is called continuity of care.

Care will continue during a transitional period, at least 90 days if you are in an active course of treatment and you request to continue receiving care from the **provider**, 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 only if the **provider** agrees to our usual terms and conditions for contracting **providers**.

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.

Also see the *Balance billing protection for out-of-network services* section for additional exceptions.

You may select a **network provider** from the online directory through your member 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.

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**
- You or your **provider precertifies** the service when required. **Precertification** 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 product 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.

Precertification

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

In-network

Your network **physician** 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**. But if your **physician** requests **precertification** and we deny it, and you still choose to get the care, you will have to pay for it yourself.

Timeframes for **precertification** are listed below. For **emergency services**, **precertification** is not required, but you should still notify us as shown. That includes an emergency interhospital transfer for a life-threatening condition for a newborn and for the mother to accompany the newborn.

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

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**.

Our clinical policy bulletins explain our policy for specific services and supplies. We use these bulletins and other resources to help determine medical necessity under our plans. You can find the bulletins and other information at https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html.

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**

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.

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

We will provide a medical exception for a non-**preferred drug** after reviewing and discussion with your prescriber if:

- We determine that the **preferred drug** is not appropriate therapy for your medical condition
- You have been receiving the non-**preferred drug** for at least 6 months before the development or revision of the **preferred drug guide** and your prescriber determines one of the following:
  - The **preferred drug** is not appropriate therapy for your medical condition
  - Changing drug therapy presents a significate health risk to you

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 Innovation Health website at https://www.innovationhealth.com/
- Submit the request in writing to Innovation Health, 3190 Fairview Park Drive, 5th floor, Suite 570, Falls Church, VA 22042

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
- The request is for a **prescription** to alleviate cancer pain
- You are going through a current course of treatment using a non-covered drug

After we receive the request and any information, we will tell you and your **provider** of our coverage determination within 24 hours, including hours on weekends.

If we deny the request for a medical exception, including **step therapy**, you have the right to request an external review by an independent review organization (IRO). If our coverage decision is one that allows you to ask for an external review, we will say that in the notice of adverse benefit determination we send you. That notice will also describe the external review process. We will tell you and your prescriber of the coverage determination of the external review no later than 72 hours after we receive your request. For expedited medical exceptions in urgent situations, we will tell you or your prescriber of the coverage determination no later than 24 hours after we received your request.

If the medical exception is approved by us, or the IRO:

- The exception will apply for the entire time of the **prescription**, or in the case of an expedited exception, for the entire time you have an urgent situation
- The cost share will be applied the same as for a drug listed in the **drug guide**

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**.

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).

Some **providers** are part of Innovation Health's **network** for some Innovation Health plans but are not considered **network providers** for your plan. For those **providers**, the **negotiated charge** is the amount that **provider** has agreed to accept for rendering services or providing **prescription** drugs to members of your plan.

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.

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 outpatient **prescription** drugs, your costs are based on:

- The type of **prescription** you're prescribed
- Where you fill the **prescription**

The plan may make some **brand-name prescription drugs** available to you at the **generic prescription drug** cost share.

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**.
- Your plan requires **precertification**, your **physician** requests it, we deny it and you get the services without **precertification**.
- You get care from someone who is not a **network provider**, except for emergency, urgent care and transplant services. See *Who provides the care* in this section for details.

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.

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, blanket, or franchise health insurance policies issued by insurers, HMOs, or health care service contractors
- Labor-management trustee plans, labor organization plans, employer organization plans, or employee benefit organization plans
- Medicare or other government benefits
- Any group health insurance contract that you can obtain or 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)

COB rule	Primary Plan	Secondary plan
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, and Medicare would be your primary payer, 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 or if you refused it, dropped it, or didn't make a request for it.

Effect of prior plan coverage

If you are in a continuation period from a prior plan at the time you join this plan you may not receive the full benefit paid under this plan. See the schedule of benefits for more information.

Your current and prior plan must be offered through the same policyholder.

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. We will make a decision within 24 hours for appeals that related to a **prescription** to alleviate cancer pain.

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 **provider**. 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 independent 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, when or where you receive the services, or even what other insurance you may have. 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. In no event will benefits be paid later than 60 days after we receive the proof of loss. Sometimes we may pay only some of the claim. Sometimes we may deny payment entirely. We may even rescind your coverage entirely. Rescission means you lose coverage going forward and going backward. If we paid claims for your past coverage, we will want the money back.

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 calendar 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 policyholder'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 calendar 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 information on requesting and gaining access to clinically appropriate **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 arbitration, 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.
- We did not follow all of the claim determination and appeal requirements Virginia. But 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

The Virginia Bureau of Insurance is also available to help you at any time during the appeal process. You are not required to complete the appeal process with us before you contact them. See the *Managed Care Ombudsman* section below for additional information.

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 the Virginia Bureau of Insurance
- Within 120 calendar days of the date you received the decision from us
- With a copy of the notice from us, along with any other important information that supports your request

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. 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 a delay in receiving health care services for your medical condition 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 a delay in receiving health care services for your medical condition 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 Office of the Managed Care Ombudsman for assistance.

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
Email: ombudsman@scc.virginia.gov

Virginia Department of Health, Office of Licensure and Certification

Your 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, VA 23233-1463

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

Utilization review

Prescription drugs covered under this plan are subject to misuse, waste or abuse utilization review by us, your **provider** or your network pharmacy. The outcome of the review may include:

- Limiting coverage of a drug to one prescribing **provider** or one network pharmacy
- Quantity, dosage or day supply limits
- Requiring a partial fill or denial of coverage

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 policyholder 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 policyholder 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 policyholder 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
        - Grandchildren in your legal custody

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 that join your plan for the following reasons:

- Birth
- Adoption or placement for adoption
- Marriage or domestic partnership
- 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
- When your dependent moves outside the service area for your employee plan

We must receive the completed enrollment information within 31 days of the date when coverage ends.

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 date when coverage ends.

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 policyholder 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 send you notice if your coverage is ending. This notice will tell you the date that your coverage ends.

When will your coverage end

Your coverage under this plan will end if:

- This plan is no longer available
- You ask to end coverage
- The policyholder asks to end coverage
- You are no longer eligible for coverage
- Your work ends
- You stop making required contributions, if any apply
- We end your coverage as described under the *Why would we end your coverage* section.
- 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.

Why would we end your coverage?

We may end your coverage if you act in a way that affects our business operations. We will give you 30 days notice in writing if we end your coverage for any of these reasons.

We will give you a 31 day advance notice if we end your coverage if 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 policyholder 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 policyholder and we have agreed to do so. It is the policyholder responsibility to let us know when your work ends. If the policyholder and we agree in writing, we will extend the limits.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

What are your COBRA rights?

The federal COBRA law usually applies to employers of group sizes of 20 or more and gives employees and 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 yourself 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
- Your employer did not end your employment because of gross misconduct, as determined by your employer and Virginia law

To continue coverage, you must:

- Apply through your employer's normal process
- Pay the required premium within 31 days of the written notice from your employer (but no later than 60 days following the date of the 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 and 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.

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.

Only the medical condition which caused the total disability is covered during your extension.

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.

You may extend coverage only for services and supplies related to the disabling condition until the earliest of:

- When you or your dependents are no longer totally disabled
- When you become covered by another health benefits plan
- 12 months of coverage

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 intellectual disability or physical handicap and depends mainly on you for support.

Proof of incapacity and dependency must be furnished to us within 31 of the child's attainment of the specified age.

Subsequent proof may be required but not more frequently than annually after the two-year period following the child's attainment of the specified age.

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
- 12 months of coverage

How you can extend coverage for your child in college on medical leave

You have the right to extend coverage for your dependent college student who takes a **medically necessary** leave of absence from school. The right to coverage will be extended until the earlier of:

- One year after the leave of absence begins
- The date coverage would otherwise end

To extend coverage the leave of absence must:

- Begin while the dependent child is suffering from a serious illness or injury.
- Cause the dependent child to lose status as a full-time student under the plan
- Be certified by the treating **physician** as **medically necessary** due to serious illness or injury.

The **physician** treating your child will be asked to keep us informed of any changes**.**

General provisions – other things you should know

Administrative provisions

How you and we will interpret this certificate

We prepared this certificate according to ERISA 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.

We are not responsible for what is done by your **providers**. Even **network providers** are not our employees or agents.

Coverage and services

Your coverage can change

Your coverage is defined by the group policy. This document may have amendments and riders too. Under certain circumstances, we, the policyholder 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 policyholder or **provider**, can do this.

Claim forms

You are required to submit a claim form to us in writing. Claim forms will be furnished by us within 15 days of notification of the claim. If we fail to provide a claim form within 15 days of notification of a claim, proof of loss will be met by giving us a written statement of the nature and extent of the loss within the time limit in the *Proof of loss* section.

Legal action

You must complete the internal appeal process, if your plan has one, before you take any legal action against us for any expense or bill. See the *Complaints, claim decisions, and, appeal procedures* section. You cannot take any action until 60 days after we receive written proof of loss.

No legal action can be brought to recover payment under any benefit after 3 years from the date written proof of loss was required to be filed. See the *Proof of loss* section.

Notice of Claim

You must give us written notice of claim within 20 days after you have incurred expenses for **covered services**. If you don't notify us within that time and can show that it was not reasonably possible to do so, we won't void or reduce your claim. But you must send us notice as soon as reasonably possible.

Payment of benefits
All benefits are payable to you. Or we will pay your beneficiary designated by you. If any **covered services** are payable to either:

- Your estate, or
- A person who is a minor or otherwise not competent to give a valid release

we may pay up to $5,000 to a person related to you by blood or marriage that we believe is fairly entitled to the benefits.

We may also pay all or any portion of the benefits to the **provider** who performed the services.

Physical examination and evaluations
At our expense, we have the right to have a **physician** of our choice examine you. This will be done at reasonable times while certification or a claim for benefits is pending or under review.

Proof of loss
You should give us written proof of loss no later than 90 days after you have incurred expenses for **covered services**. We won't void or reduce your claim if it was not reasonably possible to send us a notice and proof of loss within the required time. But you must send us a notice and proof as soon as reasonably possible. Proof of loss may not be given later than 1 year after the time proof is otherwise required, except if you are legally unable to notify us.

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 policyholder 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 policy.

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:

- Recission of coverage
- Denial of benefits
- Recovery of amounts we already paid

See the *Benefit payments and claims, Filing a claim* section for information about rescission.

You have special rights if we rescind your coverage:

- We will give you 30 days advance written notice of any rescission of coverage and 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, or our right to an **Aetna** appeal
  - Describe our internal appeal process, including any applicable time limits
  - Provide the date the advance notice ends, and the day back to which coverage is lost
- We will refund all premiums you paid

See the *Complaints, claim decisions and appeal procedures* section for information on how to submit an appeal.

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 dental, oral surgery or ambulance services, to the extent allowed by law, we will not accept an assignment to an **out-of-network provider**.

Member cost share paid by a third party

We will apply amounts paid on your behalf toward your member cost share or maximum out-of-pocket limit.

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.

Premium contribution

Your plan requires that the policyholder make premium contribution payments. After the expiration of the grace period, we will not pay for benefits if premium contributions are not made. Any decision to not pay benefits can be appealed.

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.

Effect of benefits under other plans

Health Maintenance Organization (HMO) plan

If you are eligible for and enrolled in coverage under an HMO plan offered by the policyholder, you will not have coverage under this plan on the date that your HMO plan coverage starts. If you are pregnant when you change plans, you may be eligible for an extension of benefits. Contact us for more information.

Glossary

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.

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

Coinsurance
Coinsurance is the percentage of the bill you pay after you meet your **deductible**.

Copay, copayment
Copays are flat fees for certain visits. A **copay** can be a dollar amount or percentage.

Covered service
The benefits, subject to varying cost shares, covered in this plan. These are:

- Described in the *Providing covered services* section
- Not listed as an exclusion in the *Coverage and exclusions – Providing covered services* 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

Deductible
A **deductible** is the amount you pay out-of-pocket 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.aetna.com/individuals-families/find-a-medication.html.

Emergency medical condition
A severe medical condition, regardless of the final diagnosis, showing itself by severe symptoms, including severe pain, that:

- Comes on suddenly
- Needs immediate medical care
- Leads a prudent layperson with average knowledge of health and medicine to reasonably believe that, without immediate medical care, it could result in:
  - Danger to life or physical or mental health
  - Loss of a bodily function

- Loss of function to a body part or organ
- Danger to the health of an unborn baby

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
- For a an individual or their partner who has been clinically diagnosed with gender identity disorder

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, site 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 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*.

Morbid obesity/ morbidly obese

This means:

- A weight that is at least 100 pounds over or twice the ideal weight for frame, age, height and gender as specified in the 1983 Metropolitan Life Insurance tables
- The body mass index (BMI) is:
  - Equal to or greater than 35 kilograms per meter squared with a comorbidity or coexisting condition such as:
    - High blood pressure
    - A heath or lung condition
    - Sleep apnea, or
    - Diabetes
  - 40 kilograms per meter squared and no other severe medical conditions are present

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 an 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**. A **network provider** can also be referred to as an in-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 health disorder** or **substance use disorder** issue and may include:

- Group, individual 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 3 or more continuous hours per day to individuals or group 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 covered person from the list of **PCPs** in the directory
- Supervises, coordinates and provides initial care and basic medical services to a covered person
- Shows in our records as your **PCP**

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

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

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 health disorders** (including **substance use disorders**).

Residential treatment facility
An institution specifically licensed as a **residential treatment facility** by applicable laws to provide for mental health or **substance related 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 health 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 related 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.

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.

Specialty pharmacy
A pharmacy that fills **prescriptions** for specialty 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.aetna.com/individuals-families/find-a-medication.html.

Substance related 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.

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
- Remote patient monitoring
- Any other method required by law

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 conference with or without digital image upload

Terminal illness
A medical prognosis that you are not likely to live more than 12 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 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

Innovation Health Insurance Company

Amendment

Effective date: JANUARY 1, 2023

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.

1. The *Coverage and exclusions* section in your certificate of coverage is changed with the following:

The *Acupuncture* provision is revised-

Acupuncture

Covered services include manual or electro acupuncture.

The following are not **covered services**:

- Acupressure

In the *Prescription drugs - outpatient* section, the list of services that are not **covered services** is revised-
The following are not **covered services**:

Drugs or medications

- Administered or entirely consumed at the time and place it is prescribed or provided
- Which do not require a **prescription** by law, even if a **prescription** is written, unless we have approved a medical exception
- That is therapeutically the same or an alternative to a covered **prescription** drug, unless we approve a medical exception
- Not approved by the FDA or not proven safe or effective
- Provided under your medical plan while inpatient at a healthcare facility
- Recently approved by the FDA but not reviewed by our Pharmacy and Therapeutics Committee, unless we have approved a medical exception
- That include vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
- That are used to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity or alter the shape or appearance of a sex organ unless listed as a **covered service**
- That are used for the purpose of weight gain or loss including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants or other medications
- That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature unless there is evidence that the member meets one or more clinical criteria detailed in our **precertification** and clinical policies

- Off-label drug use except as described in the *Coverage and exclusions, Prescription drugs – outpatient, Off-label use* section
- **Prescription** drugs:
  - That are ordered by a dentist or prescribed by an oral surgeon in relation to the removal of teeth or **prescription** drugs for the treatment to a dental condition

- That are considered oral dental preparations and fluoride rinses except pediatric fluoride tablets or drops as specified on the plan's **drug guide**
- That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, or drugs obtained for use by anyone other than the member as identified on the ID card

A new provision is added called *Telemedicine*-

Telemedicine

Covered services include **telemedicine** consultations when provided by a **physician**, **specialist, behavioral health provider** or other **telemedicine provider** acting within the scope of their license.

Covered services for **telemedicine** consultations are available from a number of different kinds of **providers** under your plan. Log in to your member website at https://www.innovationhealth.com/ to review our **telemedicine provider** listing and Contact us to get more information about your options, including specific cost sharing amounts.

The following are not **covered services**:

- Telephone calls
- **Telemedicine** kiosks

The *Walk-in clinic* provision is revised-

Walk-in clinic

Covered services include, but are not limited to, health care services provided through 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

2. The *General plan exclusions* section in your certificate of coverage is changed with the following:

The *Behavioral health treatment* exclusion is revised-

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. Therapy by a licensed counselor will be covered if provided on an outpatient basis as part of a wilderness treatment program.
- 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

The *Cosmetic services and plastic surgery* exclusion is revised-

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, except where described in the *Coverage and exclusions* section

3. In the *How your plan works* section, the following is changed:
The *Who provides the care*, *Medical necessity and precertification requirements*, *Precertification*, *Types of services that require precertification* section is revised:

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
Gene-based, cellular and other innovative therapies (GCIT)	Applied behavior analysis
Gender affirming treatment	ART services
Obesity (bariatric) **surgery**	Complex imaging
Stays in a **hospice** facility	Comprehensive **infertility** services
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 disorders** and **substance use disorders**	Gene-based, cellular and other innovative therapies (GCIT)
Stays in a **skilled nursing facility**	Gender affirming treatment
	Injectables, (immunoglobulins, growth hormones, multiple sclerosis medications, osteoporosis medications, Botox, hepatitis C medications)
	Kidney dialysis
	Knee **surgery**
	Outpatient back **surgery** not performed in a **physician's** office
	Partial hospitalization treatment – **mental health disorders** and **substance use disorders** treatment
	Private duty nursing services
	Sleep studies
	Transcranial magnetic stimulation (TMS)
	Wrist **surgery**

Contact us to get a complete 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**.

Our clinical policy bulletins explain our policy for specific services and supplies. We use these bulletins and other resources to help determine medical necessity under our plans. You can find the bulletins and other information at https://www.innovationhealth.com/health-care-professionals/clinical-policy-bulletins.html.

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**.

Step therapy is a type of **precertification** where you must try one or more prerequisite drugs before a step therapy drug is covered. A 'prerequisite' is something that is required before something else. Prerequisite drugs are FDA-approved, may cost less and treat the same condition. If you don't try the prerequisite drugs first, the step therapy drug may not be covered.

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

The *Who provides the care*, *Medical necessity, referral, and precertification requirements*, *Requesting a medical exception* section is revised-

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

We will cover a drug not in the **drug guide** without additional cost sharing beyond what is required of drugs in the **drug guide** if:

- We determine, after consultation with your **provider**, that the drug in the **drug guide** is an inappropriate therapy for your condition; or
- You have been receiving the drug not in the **drug guide** for at least 6 months prior to its exclusion from the **drug guide** and your **provider** determines that:
  - The drug in the **drug guide** is an inappropriate therapy for your condition; or
  - Changing drug therapy presents a significant health risk to you

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 Innovation Health website at https://www.innovationhealth.com/
- Submit the request in writing to Innovation Health, 3190 Fairview Park Drive, 5th floor, Suite 570, Falls Church, VA 22042

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
- The request is for a **prescription** to alleviate cancer pain
- You are going through a current course of treatment using a non-covered drug

After we receive the request and any information, we will tell you and your **provider** of our coverage determination within 24 hours, including hours on weekends.

If we deny the request for a medical exception, including **step therapy**, you have the right to request an external review by an independent review organization (IRO). If our coverage decision is one that allows you to ask for an external review, we will say that in the notice of adverse benefit determination we send you. That notice will also describe the external review process. We will tell you and your prescriber of the coverage determination of the external review no later than 72 hours after we receive your request. For expedited medical exceptions in urgent situations, we will tell you or your prescriber of the coverage determination no later than 24 hours after we received your request.

If the medical exception is approved by us, or the IRO:

- The exception will apply for the entire time of the **prescription**, or in the case of an expedited exception, for the entire time you have an urgent situation
- The cost share will be applied the same as for a drug listed in the **drug guide**

The *Benefit payments and claims*, *Filing a claim* section is revised-

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, your or your **provider** must send us the bill within 15 months of the date you received services, unless you are legally unable to notify use. You must send it to us 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 **necessity** of the service you received, when or where you receive the services, or even what other insurance you may have. 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 40 days from when we receive all the information necessary. In no event will benefits be paid later than 60 days after we receive the proof of loss. Sometimes we may pay only some of the claim. Sometimes we may deny payment entirely. We may even rescind your coverage entirely. Rescission means you lose coverage going forward and going backward. If we paid claims for your past coverage, we will want the money back. We will refund all premiums you paid.

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.

5. The *Glossary* section in your certificate of coverage is changed:

Brand-name prescription drug

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

Drug guide

A list of **prescription** and OTC drugs and devices established by us or an affiliate. It does not include all **prescription** and OTC 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/individuals-families/find-a-medication.html.

Generic prescription drug

An FDA-approved drug with the same intended use as the brand-name product, that is considered to be as effective as the brand-name product. It offers the same:

- Dosage
- Safety
- Strength
- Quality
- Performance

Specialty prescription drug

An FDA-approved **prescription** drug that typically has a higher cost and requires special handling, special storage or monitoring. These drugs may be administered:

- Orally (mouth)
- Topically (skin)
- By inhalation (mouth or nose)
- By injection (needle)

Specialty pharmacy

A pharmacy that fills **prescriptions** for specialty drugs.

Telemedicine

A consultation between you and a **physician**, **specialist**, or **behavioral health provider**, or **telemedicine provider** who is performing a clinical medical or behavioral health service by means of electronic communication, including remote patient monitoring services.

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 conference with or without digital image upload

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

Sunil Budhrani
Chief Executive Officer

Innovation Health Insurance Company

Amendment IH COC Amend-2022 01
Amends form: IH HCOC 09
Issue Date JANUARY 1, 2023

Additional Information Provided by

SAMPLE

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). It is not a part of your booklet-certificate. Your Plan Administrator has determined that this information together with the information contained in your booklet-certificate is the Summary Plan Description required by ERISA.

In furnishing this information, Aetna is acting on behalf of your Plan Administrator who remains responsible for complying with the ERISA reporting rules and regulations on a timely and accurate basis.

Name of Plan:
Refer to your Plan Administrator for this information

Employer Identification Number:
SAMPLE

Plan Number:
SAMPLE

Type of Plan:
SAMPLE

Type of Administration:
Group Insurance Policy with:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Plan Administrator:
SAMPLE

Telephone Number: SAMPLE

Agent For Service of Legal Process:
SAMPLE

Service of legal process may also be made upon the Plan Administrator

End of Plan Year:
SAMPLE

Source of Contributions:
SAMPLE

Procedure for Amending the Plan:

The Employer may amend the Plan from time to time by a written instrument signed by the person designated by SAMPLE.

ERISA Rights

As a participant in the group insurance plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), and an updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Receive a copy of the procedures used by the Plan for determining a qualified domestic relations order (QDRO) or a qualified medical child support order (QMCSO).

Continue Group Health Plan Coverage

Continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in your interest and that of other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to $ 110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the status of a domestic relations order or a medical child support order, you may file suit in a federal court.

If it should happen that plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, you should contact:

- the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or
- the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that you, your physician, or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain precertification for any days of confinement that exceed 48 hours (or 96 hours). For information on precertification, contact your plan administrator.

Notice Regarding Women's Health and Cancer Rights Act

Under this health plan, as required by the Women's Health and Cancer Rights Act of 1998, coverage will be provided to a person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy for:

(1) all stages of reconstruction of the breast on which a mastectomy has been performed;
(2) surgery and reconstruction of the other breast to produce a symmetrical appearance;
(3) prostheses; and
(4) treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be provided in accordance with the plan design, limitations, copays, deductibles, and referral requirements, if any, as outlined in your plan documents.

If you have any questions about our coverage of mastectomies and reconstructive surgery, please contact the Member Services number on your ID card.

For more information, you can visit this U.S. Department of Health and Human Services website, http://www.cms.gov/home/regsguidance.asp, and this U.S. Department of Labor website, https://www.dol.gov/agencies/ebsa/employers-and-advisers/plan-administration-and-compliance/health-plans.

IMPORTANT HEALTH CARE REFORM NOTICES

CHOICE OF PROVIDER

If your Aetna plan generally requires or allows the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If the plan or health insurance coverage designates a primary care provider automatically, then until you make this designation, Aetna designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your Employer or, if you are a current member, your Aetna contact number on the back of your ID card.

If your Aetna plan allows for the designation of a primary care provider for a child, you may designate a pediatrician as the primary care provider.

If your Aetna plan provides coverage for obstetric or gynecological care and requires the designation of a primary care provider then you do not need prior authorization from Aetna or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your Employer or, if you are a current member, your Aetna contact number on the back of your ID card.

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's network.

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.

Confidentiality Notice

Aetna considers personal information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. By "personal information," we mean information that relates to a member's physical or mental health or condition, the provision of health care to the member, or payment for the provision of health care or disability or life benefits to the member. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify the member.

When necessary or appropriate for your care or treatment, the operation of our health, disability or life insurance plans, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), payors (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your plan), other insurers, third party administrators, vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. In our health plans, participating network providers are also required to give you access to your medical records within a reasonable amount of time after you make a request.

Some of the ways in which personal information is used include claim payment; utilization review and management; medical necessity reviews; coordination of care and benefits; preventive health, early detection, vocational rehabilitation and disease and case management; quality assessment and improvement activities; auditing and anti-fraud activities; performance measurement and outcomes assessment; health, disability and life claims analysis and reporting; health services, disability and life research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. We consider these activities key for the operation of our health, disability and life plans. To the extent permitted by law, we use and disclose personal information as provided above without member consent. However, we recognize that many members do not want to receive unsolicited marketing materials unrelated to their health, disability and life benefits. We do not disclose personal information for these marketing purposes unless the member consents. We also have policies addressing circumstances in which members are unable to give consent.

To obtain a copy of our Notice of Privacy Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please call the toll-free Member Services number on your ID card or visit our Internet site at www.aetna.com.

Continuation of Coverage During an Approved Leave of Absence Granted to Comply With Federal Law

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by Family and Medical Leave Act of 1993 (FMLA). If your Employer grants you an approved FMLA leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be subject to prior written agreement between Aetna and your Employer.

If your Employer grants you an approved FMLA leave in accordance with FMLA, you may, during the continuance of such approved FMLA leave, continue Health Expense Benefits for you and your eligible dependents.

At the time you request the leave, you must agree to make any contributions required by your Employer to continue coverage. Your Employer must continue to make premium payments.

If Health Expense Benefits has reduction rules applicable by reason of age or retirement, Health Expense Benefits will be subject to such rules while you are on FMLA leave.

Coverage will not be continued beyond the first to occur of:

- The date you are required to make any contribution and you fail to do so.
- The date your Employer determines your approved FMLA leave is terminated.
- The date the coverage involved discontinues as to your eligible class. However, coverage for health expenses may be available to you under another plan sponsored by your Employer.

Any coverage being continued for a dependent will not be continued beyond the date it would otherwise terminate.

If Health Expense Benefits terminate because your approved FMLA leave is deemed terminated by your Employer, you may, on the date of such termination, be eligible for Continuation Under Federal Law on the same terms as though your employment terminated, other than for gross misconduct, on such date. If the group contract provides any other continuation of coverage (for example, upon termination of employment, death, divorce or ceasing to be a defined dependent), you (or your eligible dependents) may be eligible for such continuation on the date your Employer determines your approved FMLA leave is terminated or the date of the event for which the continuation is available.

If you acquire a new dependent while your coverage is continued during an approved FMLA leave, the dependent will be eligible for the continued coverage on the same terms as would be applicable if you were actively at work, not on an approved FMLA leave.

If you return to work for your Employer following the date your Employer determines the approved FMLA leave is terminated, your coverage under the group contract will be in force as though you had continued in active employment rather than going on an approved FMLA leave provided you make request for such coverage within 31 days of the date your Employer determines the approved FMLA leave to be terminated. If you do not make such request within 31 days, coverage will again be effective under the group contract only if and when Aetna gives its written consent.

If any coverage being continued terminates because your Employer determines the approved FMLA leave is terminated, any Conversion Privilege will be available on the same terms as though your employment had terminated on the date your Employer determines the approved FMLA leave is terminated.

INNOVATION HEALTH INSURANCE COMPANY

Schedule of Benefits

If this is an ERISA plan, you have certain rights under this plan. Please contact your employer for additional information.

Prepared for:

Policyholder:	SAMPLE
Policyholder number:	GP-SAMPLE
Group policy effective date:	JANUARY 1, 2023
Plan name:	Innovation Health Open Access Elect Choice EPO
Schedule of Benefits:	
Plan effective date:	January 1, 2023
Plan issue date:	January 1, 2023

Underwritten by Innovation Health Insurance Company in the Commonwealth of Virginia

"**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** and **copayments**, if any, listed in the schedule below are the amounts that you pay for **covered services**.
  - For the **covered services** under your medical plan, you will be responsible for the dollar amount
  - For pharmacy benefits where a percentage cost share acts like a **copayment**, you will be responsible for the percentage amount
- **Coinsurance** amounts, if any, listed in the schedule below are what the plan will pay for **covered services**.
- Sometimes your cost share shows a combination of your dollar amount **copayment** that you will be responsible for and the **coinsurance** percentage that your plan will pay.
- You are responsible to pay any **deductibles**, **copayments** and remaining **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:
  - Based on a rolling, 12 month period starting with the date of your most recent visit under this plan

  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.

Important note:
Covered services are subject to the Calendar Year **deductible**, **maximum out-of-pocket**, limits, **copayment** or **coinsurance** unless otherwise stated in this schedule.

Under this plan, you will:

1. Pay your **copayment**
2. Then pay any remaining **deductible**
3. Then pay your **coinsurance**

Your **copayment** does not apply to any **deductible**.

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 in-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.

Contact us
We are here to answer questions. See the *Contact us* section in your certificate.

Innovation Health Insurance Company's group policy 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

Deductible
You have to meet your **deductible** before this plan pays for benefits.

Deductible type	In-network
Individual	$XX per year
Family	$XX per year

Deductible waiver
There is no in-network **deductible** for the following **covered services**:

- Preventive care
- Family planning services – female contraceptives

Deductible and cost share waiver for risk reducing breast cancer prescription drugs
The **prescription** drug **deductible** and per **prescription** cost share will not apply to risk reducing breast cancer **prescription** drugs when obtained at a network pharmacy. This means they will be paid at 100%.

Deductible and cost share waiver for contraceptives (birth control)
The **prescription** drug **deductible** and per **prescription** cost share will not apply to female contraceptive methods when obtained at a network pharmacy. This means they will be paid at 100%. This includes certain OTC and generic contraceptive **prescription** drugs and devices for each of the methods identified by the FDA. If a **generic prescription drug** is not available, the **brand-name prescription drug** for that method will be paid at 100%.

The **prescription** drug **deductible** and cost share will apply to **prescription** drugs that have a generic equivalent or alternative available within the same therapeutic drug class obtained at a network pharmacy unless we approve a medical exception. A therapeutic drug class is a group of drugs or medications that have a similar or identical mode of action or are used for the treatment of the same or similar disease or injury.

Deductible and cost share waiver for tobacco cessation prescription and OTC drugs
The **prescription** drug **deductible** and the per **prescription** cost share will not apply to the first two 90-day treatment programs for tobacco cessation **prescription** and OTC drugs when obtained at a network **retail pharmacy**. This means they will be paid at 100%. Your per **prescription** cost share will apply after those two programs have been exhausted.

Per admission copayment

Per admission copayment type	In-network
Per admission **copayment**	$XX per day up to 5 per admission

Maximum out-of-pocket limit

Includes the **deductible.**

Maximum out-of-pocket type	In-network
Individual	$XX per year
Family	$XX per year

General coverage provisions

This section explains the **deductible, maximum out-of-pocket limit** and limitations listed in this schedule.

Deductible provisions

In-network **covered services** will apply only to the in-network **deductible**.

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.

Deductible credit

If you paid part or all of your **deductible** under other coverage for the year that this plan went into effect, we will deduct the amount paid under the other coverage from the **deductible** on this plan for the same year. If we ask, you must submit a detailed explanation of benefits (EOB) showing the dates and amount of the **deductible** met from the other coverage in order to receive the credit.

Copayment

This is the dollar amount you pay for **covered services**. In most plans, you pay this after you meet your **deductible** limit.

Per admission copayment

This is the amount you are required to pay when you or a covered dependent have a **stay** in an inpatient facility.

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**. **Covered services** that are subject to the **maximum out-of-pocket limit** include those provided under the medical plan and the outpatient **prescription** drug plan.

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
- Costs for non-urgent use of an urgent care **provider**

Your financial responsibility and decisions regarding benefits

We base your financial responsibility for the cost of **covered services** on when the service or supply is provided, not when payment is made. We calculate your **coinsurance**, if any, based on **negotiated charge**. 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 policy.

Outpatient prescription drug maximum out-of-pocket limit provisions

Covered services that are subject to the **maximum out-of-pocket limit** include **covered services** provided under the medical plan and the **prescription** drug plan.

The **maximum out-of-pocket limit** is the most you will pay per year in **copayments**, **coinsurance** and **deductible**, if any, for **covered services**. This plan may have an individual and family **maximum out-of-pocket limit**.

Covered services

Acupuncture

Description	In-network
Acupuncture	$XX then the plan pays XX% per visit, no **deductible** applies

Visit limit per year	XX

Ambulance services

Description	In-network
Emergency services	XX% per trip after **deductible**
Description	**In-network**
Non-emergency services	XX% per trip after **deductible**

Applied behavior analysis

Description	In-network
Applied behavior analysis	Covered based on type of service and where it is received

Autism spectrum disorder

Description	In-network
Diagnosis and testing	Covered based on type of service and where it is received
Treatment	Covered based on type of service and where it is received
Occupational (OT), physical (PT) and speech (ST) therapy for autism spectrum disorder	Covered based on type of service and where it is received
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
Inpatient services-**room and board** including **residential treatment facility**	$XX per day then the plan pays XX% for 5 days per admission then the plan pays XX% after **deductible**

Description	In-network
Outpatient office visit to a **physician** or **behavioral health provider**	$XX then the plan pays XX% per visit, no **deductible** applies
Physician or **behavioral health provider telemedicine** consultation	$XX then the plan pays XX% per visit, no **deductible** applies
Outpatient **mental health disorders telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider**	XX% per visit, no **deductible** applies

Description	In-network
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, no **deductible** applies

Substance use disorders treatment

Includes **detoxification**, rehabilitation and **residential treatment facility**

Coverage provided is the same as for any other illness

Description	In-network
Inpatient services-**room and board** during a **hospital stay**	$XX per day then the plan pays XX% for 5 days per admission then the plan pays XX% after **deductible**

Description	In-network
Outpatient office visit to a **physician** or **behavioral health provider**	$XX then the plan pays XX% per visit, no **deductible** applies
Physician or **behavioral health provider telemedicine** consultation	$XX then the plan pays XX% per visit, no **deductible** applies
Outpatient **telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider**	XX% per visit, no **deductible** applies

Description	In-network
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, no **deductible** applies

Clinical trials

Description	In-network
Experimental or investigational therapies	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

Diabetic services, supplies, equipment, and self-care programs

Description	In-network
Diabetic services	Covered based on type of service and where it is received
Diabetic supplies	Covered based on type of service and where it is received
Diabetic equipment	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

Durable medical equipment (DME)

Description	In-network
DME	XX% per item after **deductible**

Emergency services

Description	In-network	Out-of-network
Emergency room	$XX then the plan pays XX% per visit, no **deductible** applies	Paid same as in-network

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
PT, OT therapies	Covered based on type of service and where it is received

Speech therapy (ST)

Description	In-network
ST	Covered based on type of service and where it is received

Hearing exams

Description	In-network
Hearing exams	Covered based on type of service and where it is received
Visit limit	1 visit every XX months

Hemophilia and congenital bleeding disorder

Description	In-network
Home treatment supervised by a state-approved hemophilia treatment center	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
Home health care	XX% per visit after **deductible**

Visit limit per year	XX

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
Inpatient services - **room and board**	$XX per day then the plan pays XX% for 5 days per admission then the plan pays XX% after **deductible**

Description	In-network
Outpatient services	XX% per visit after **deductible**

Limit per lifetime	unlimited

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
Inpatient services - **room and board**	$XX per day then the plan pays XX% for 5 days per admission then the plan pays XX% after **deductible**

Infertility services

Basic infertility

Description	In-network
Treatment of basic **infertility**	Covered based on type of service and where it is received

Jaw joint disorder

Includes TMJ

Description	In-network
Jaw joint disorder treatment	Covered based on type of service and where it is received

Lymphedema

Description	In-network
Lymphedema	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
Inpatient services – **room and board**	$XX per day then the plan pays XX% for 5 days per admission then the plan pays XX% after **deductible**
Services performed in **physician** or **specialist** office or a facility	XX% per visit after **deductible**
Other services and supplies	XX% after **deductible**

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
Formula and enteral nutrition products	XX% per item, no **deductible** applies
Equipment, supplies and services	Covered based on type of service and where it is received

Oral and maxillofacial treatment (mouth, jaws and teeth)

Description	In-network
Treatment of mouth, jaws and teeth	Covered based on type of service and where it is received

Outpatient prescription drugs

Preferred generic prescription drugs

Description	In-network
30 day supply at a **retail pharmacy**	$XX, no **deductible** applies
90 day supply at a **retail pharmacy**	$XX, no **deductible** applies
90 day supply at a **mail order pharmacy**	$XX, no **deductible** applies

Value prescription drugs

Description	In-network
30 day supply at a **retail pharmacy**	$XX, no **deductible** applies
90 day supply at a **retail pharmacy**	$XX, no **deductible** applies
90 day supply at a **mail order pharmacy**	$XX, no **deductible** applies

Preferred brand-name prescription drugs

Description	In-network
30 day supply at a **retail pharmacy**	$XX, no **deductible** applies
90 day supply at a **retail pharmacy**	$XX, no **deductible** applies
90 day supply at a **mail order pharmacy**	$XX, no **deductible** applies

Non-preferred generic prescription drugs

Description	In-network
30 day supply at a **retail pharmacy**	$XX, no **deductible** applies
90 day supply at a **retail pharmacy**	$XX, no **deductible** applies
90 day supply at a **mail order pharmacy**	$XX, no **deductible** applies

Non-preferred brand-name prescription drugs

Description	In-network
30 day supply at a **retail pharmacy**	$XX, no **deductible** applies
90 day supply at a **retail pharmacy**	$XX, no **deductible** applies
90 day supply at a **mail order pharmacy**	$XX, no **deductible** applies

Preferred specialty prescription drugs

Description	In-network
30 day supply at a **specialty pharmacy** or a **retail pharmacy**	XX% but no more than $XX, no **deductible** applies

Non-preferred specialty prescription drugs

Description	In-network
30 day supply at a **specialty pharmacy** or a **retail pharmacy**	XX% but no more than $XX, no **deductible** applies

Anti-cancer drugs taken by mouth

Description	In-network
30 day supply at a **retail pharmacy**	$XX, no **deductible** applies
90 day supply at a **retail pharmacy**	$XX**,** no **deductible** applies
90 day supply at a **mail order pharmacy**	$XX, no **deductible** applies

Contraceptives (birth control)

Brand-name prescription drugs and devices are covered at 100% when a generic is not available

Description	In-network
Up to a 12-month supply of oral generic **prescription drugs** 30 day supply of all other generic and OTC drugs and devices	$XX, no **deductible** applies
Up to a 12-month supply of oral generic **prescription drugs** 30 day supply of all other **brand-name prescription drugs** and devices	Paid based on the tier of drug in the schedule

Diabetic drugs and insulin

Description	In-network	Out-of-network
30 day supply at **retail pharmacy**	Paid based on the tier of drug in the schedule	Paid based on the tier of drug in the schedule
90 day supply at **mail order pharmacy**	Paid based on the tier of drug in the schedule	Paid based on the tier of drug in the schedule

Important note:
Regardless of tier prescribed, you will not be required pay a cost-sharing amount of more than $50 per 30-day supply of a covered **prescription** insulin drug filled at a **network pharmacy**.

Preventive care drugs and supplements

Description	In-network
Preventive care drugs and supplements	$XX, no **deductible** applies
Limits	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF) For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section

Risk reducing breast cancer drugs

Description	In-network
Risk reducing breast cancer **prescription** drugs	$XX, no **deductible** applies
Limits	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF) For a current list of risk reducing breast cancer drugs or more information, see the *Contact us* section

Tobacco cessation drugs

Description	In-network
Tobacco cessation **prescription** and OTC drugs	$XX, no **deductible** applies
Limits	Subject to any sex, age, medical condition, family history and frequency guidelines in the recommendations of the USPSTF. For a current list of covered tobacco cessation drugs or more information, see the *Contact us* section. See the *Other services* section of this schedule for more information.

Outpatient prescription drug important note:
If a **provider** prescribes a covered **brand-name prescription drug** when a **generic prescription drug** equivalent is available and specifies "Dispense As Written" (DAW), you will pay the cost share for the brand-name drug. If a **provider** does not specify DAW and you request a covered **brand-name prescription drug**, you will be responsible for the cost difference between the brand-name drug and the generic drug, plus the cost share that applies to the brand-name drug.

Outpatient surgery

Description	In-network
At **hospital** outpatient department	$XX then the plan pays XX% per visit after **deductible**

Physician and specialist services

Physician services-general or family practitioner

Description	In-network
Physician office hours (not-surgical, not preventive)	$XX then the plan pays XX% per visit, no **deductible** applies
Physician surgical services	$XX then the plan pays XX% per visit, no **deductible** applies

Description	In-network
Physician telemedicine consultation	$XX then the plan pays XX% per visit, no **deductible** applies

Description	In-network
Physician visit during inpatient **stay**	XX% per visit after **deductible**

Specialist

Description	In-network
Specialist office hours (not surgical, not preventive)	$XX then the plan pays XX% per visit, no **deductible** applies
Specialist surgical services	$XX then the plan pays XX% per visit, no **deductible** applies

Specialist

Description	In-network
Specialist telemedicine consultation	$XX then the plan pays XX% per visit, no **deductible** applies

All other services not shown above	
Description	**In-network**
All other services	XX% per visit after **deductible**

Preventive care

Description	In-network
Preventive care services	XX% per visit, no **deductible** applies
Breast feeding counseling and support	XX% per visit, 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
Counseling for alcohol or drug misuse	XX% per visit, no **deductible** applies
Counseling for alcohol or drug misuse visit limit	5 visits/12 months
Counseling for obesity, healthy diet	XX% per visit, no **deductible** applies
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	XX% per visit, no **deductible** applies
Counseling for sexually transmitted infection visit limit	2 visits/12 months
Counseling for tobacco cessation	XX% per visit, no **deductible** applies
Counseling for tobacco cessation visit limit	8 visits/12 months
Family planning services (female contraception counseling)	XX% per visit, no **deductible** applies
Family planning services (female contraception counseling) limit	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting
Immunizations	XX%, no **deductible** applies
Immunizations limit	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 screenings	XX% per visit, no **deductible** applies
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
Routine lung cancer screening	XX% per visit, no **deductible** applies
Routine lung cancer screening limit	1 screenings every 12 months Screenings that exceed this limit covered as outpatient diagnostic testing
Routine physical exam	XX% per visit, no **deductible** applies
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 GYN exam	XX% per visit, no **deductible** applies
Well woman GYN exam limit	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration
Limit	1 visit

Private duty nursing

Up to eight hours equals one shift

Description	In-network
Outpatient services	XX% per visit after **deductible**

Visit/shift limit per year	XX

Prosthetic devices

Description	In-network
Prosthetic devices	XX% per item after **deductible**

Reconstructive surgery and supplies

Including breast **surgery**

Description	In-network
Surgery and supplies	Covered based on type of service and where it is received

Short-term rehabilitation services

Cardiac rehabilitation

Description	In-network
Cardiac rehabilitation	Covered based on type of service and where it is received

Pulmonary rehabilitation

Description	In-network
Pulmonary	Covered based on type of service and where it is received

Cognitive rehabilitation

Description	In-network
Cognitive rehabilitation	Covered based on type of service and where it is received

Physical, occupational and speech therapies

Description	In-network
	XX% per visit after **deductible**

Physical, occupational and speech therapies

Description	In-network
Visit limit per year All therapies combined	XX

Spinal Manipulation

Description	In-network
	$XX then the plan pays XX% per visit, no **deductible** applies

Skilled nursing facility

Description	In-network
Inpatient services - **room and board**	$XX per day then the plan pays XX% for 5 days per admission then the plan pays XX% after **deductible**
Other inpatient services and supplies	XX% per admission after **deductible**

Day limit per year	XX

Tests, images and labs – outpatient

Diagnostic complex imaging services

Description	In-network
	$XX then the plan pays XX% per visit, no **deductible** applies

Diagnostic lab work

Description	In-network
	XX% per visit, no **deductible** applies

Diagnostic x-ray and other radiological services

Description	In-network
	XX% per visit after **deductible**

Therapies

Chemotherapy

Description	In-network
Chemotherapy services	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 Innovation Health'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
In **physician** office	$XX then the plan pays XX% per visit, no **deductible** applies
At an infusion location	Covered based on type of service and where it is received
In the home	$XX then the plan pays XX% per visit, no **deductible** applies
At **hospital** outpatient department	XX% per visit after **deductible**
At facility that is not a **hospital**	XX% per visit after **deductible**

Radiation therapy

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

Respiratory therapy

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

Transplant services

Description	In-network (IOE facility)
Inpatient services and supplies	$XX per day then the plan pays XX% for 5 days per transplant then the plan pays XX% after **deductible**
Physician services	Covered based on type of service and where it is received

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
Urgent care facility	$XX then the plan pays XX% per visit, no **deductible** applies

Non-urgent use of an urgent care facility or **provider**	Not covered

Vision care

Performed by an ophthalmologist or optometrist and includes refraction

Description	In-network
	XX% per visit, no **deductible** applies

Visit limit	1 visit every XX 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
Non-emergency services	XX% per visit, no **deductible** applies	$XX then the plan pays XX% per visit, no **deductible** applies
Preventive immunizations	XX% per visit, no **deductible** applies	XX% per visit, no **deductible** applies
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**
Preventive screening and counseling services	XX% per visit, no **deductible** applies	XX% per visit, no **deductible** applies
Preventive screening and counseling limits	See the *Preventive care services* section of the schedule	See the *Preventive care services* section of the schedule

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 **provider** 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.