Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-855-330-4545.

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 discriminate on the basis of race, color, national origin, age, disability, or sex. Innovation Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Innovation Health provides 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 1-855-330-4545.

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 (CA HMO customers: PO Box 24030 Fresno, CA 93779),

1-800-648-7817, TTY: 711,

Fax: 859-425-3379 (CA HMO customers: 860-262-7705), 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).

Language Assistance Taglines

TTY: 711

For language assistance in English call 1-855-330-4545 at no cost. (English)

Para obtener asistencia lingüística en español, llame sin cargo al 1-855-330-4545. (Spanish)

欲取得繁體中文語言協助，請撥打1-855-330-4545，無需付費。(Chinese)

Pour une assistance linguistique en français appeler le 1-855-330-4545 sans frais. (French)

Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-855-330-4545 nang walang bayad. (Tagalog)

Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-855-330-4545 an. (German)

በ አማርኛ የቋንቋ እገዛ ለማግኘት በ 1-855-330-4545 በነጻ ይደውሉ (Amharic)

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-855-330-4545. (Arabic)

বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-855-330-4545 -তে কল করুন। (Bengali)

(Hindi) हिन्दी में भाषा सहायता के लिए, 1-855-330-4545 पर मुफ्त कॉल करें।

Maka enyemaka asụsụ na Igbo kpọọ 1-855-330-4545 na akwụghị ụgwọ ọ bụla (Ibo)

한국어로 언어 지원을 받고 싶으시면 무료 통화번호인1-855-330-4545 번으로 전화해 주십시오. (Korean)

Ɓé m̀ ké gbo-kpá-kpá dyé pídyi ɖé Ɓǎsɔ́ɔ̀-wùɖùǔn wɛ̃ɛ, ɖá 1-855-330-4545 (Kru-Bassa)

برای راهنمایی به زبان فارسی با شماره 1-855-330-4545 بدون هیچ هزینه ای تماس بگیرید. انگلیسی (Persian)

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-855-330-4545. (Russian)

اُردو میں لسانی معاونت کے لیے 1-855-330-4545 پر مفت کال کریں۔ (Urdu)

Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-855-330-4545. (Vietnamese)

Fún ìrànlọwọ nípa èdè (Yorùbá) pe 1-855-330-4545 lái san owó kankan rárá. (Yoruba)

Innovation Health Insurance Company

Preferred Provider Organization (PPO) Medical Plan

Booklet-Certificate

Prepared exclusively for

Plan Name:	**VA IH Gold PPO 1000 100/50**
PPID:	**VAP0030010118871**

Welcome

Thank you for choosing **Innovation Health Insurance Company**.

This is your booklet-certificate. It is one of three documents that together describe the benefits covered by your plan for in-network and out-of-network coverage.

This booklet-certificate will tell you about your **covered benefits** – what they are and how you get them. If you become covered, this booklet-certificate becomes your certificate of coverage under the group policy, and it replaces all certificates describing similar coverage that we sent to you before. The second document is the schedule of benefits. It tells you how we share expenses for **eligible health services** and tells you about limits – like when your plan covers only a certain number of visits.

The third document is the group policy between **Innovation Health Insurance Company** (**Innovation Health**) and your **policyholder**. Ask your employer if you have any questions about the group policy.

Sometimes, these documents have amendments or inserts which we will send you. These change or add to the documents they're part of. When you receive these, they are considered part of your plan for coverage.

Where to next? Try the *Let's get started!* section. *Let's get started!* gives you a summary of how your plan works. The more you understand, the more you can get out of your plan.

Welcome to your **Innovation Health** plan.

Table of Contents

Let's get started!

Here are some basics. First things first – some notes on how we use words. Then we explain how your plan works so you can get the most out of your coverage. But for all the details – this is very important – you need to read this entire booklet-certificate and the schedule of benefits. And if you need help or more information, we tell you how to reach us.

Some notes on how we use words

- When we say "you" and "your", we mean both you and any covered dependents, if dependent coverage is available under your plan.
- When we say "us", "we", and "our", we mean **Innovation Health**.
- Some words appear in **bold** type. We define them in the *Glossary* section.

Sometimes we use technical medical language that is familiar to medical **providers**.

What your plan does – providing covered benefits

Your plan provides **covered benefits**. These are **eligible health services**. Your plan has an obligation to pay for **eligible health services**.

How your plan works – starting and stopping coverage

Your coverage under the plan has a start and an end. You start coverage after you complete the eligibility and enrollment process. To learn more see the *Who the plan covers* section.

Your coverage typically ends when you leave your job. Family members can lose coverage for many reasons, such as growing up and leaving home. To learn more see the *When coverage ends* section.

Ending coverage under the plan doesn't necessarily mean you lose coverage with us. See the *Special coverage options after your plan coverage ends* section.

How your plan works while you are covered in-network

Your in-network coverage helps you:

- Get and pay for a lot of – but not all – health care services. These are **eligible health services**.
- Pay less cost share when you use a **network provider**.

1. **Eligible health services**

   Doctor and **hospital** services are the base for many other services. You'll probably find the preventive care and wellness, **emergency services** and **urgent condition** coverage especially important. But the plan won't always cover the services you want. Sometimes it doesn't cover health care services your doctor will want you to have.

   So what are **eligible health services**? They are health care services that meet these three requirements:

   - They appear in the *Eligible health services under your plan* section.
   - They are not listed in the *What your plan doesn't cover –exceptions and exclusions* section. (We will refer to this section as the "*exceptions*" section in the rest of this booklet-certificate.)
   - They are not beyond any limits in the schedule of benefits.

2. Providers

Our directory of doctors, **hospitals** and other health care **providers** are there to give you the care you need. You can find **network providers** and see important information about them most easily on our online **provider directory**. Just log into your secure member website at www.innovationhealth.com.

You may choose a **primary care physician** (we call that doctor your **PCP**) to oversee your care. Your **PCP** will provide your routine care, and send you to other **providers** when you need specialized care. You don't have to access care through your **PCP**. You may go directly to network **specialists** and **providers** for **eligible health services**.

Your plan often will pay a bigger share for **eligible health services** that you get through your **PCP**, so choose a **PCP** as soon as you can.

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

Female Members age 13 or older may choose a **network provider** who is an Obstetrician/Gynecologist (OB-GYN) physician in addition to their **PCP** and seek well woman **eligible health services** directly from their OB-GYN physician.

3. Paying for eligible health services– the general requirements

There are several general requirements for the plan to pay any part of the expense for an **eligible health service**. They are:

- The **eligible health service** is **medically necessary**
- You get the **eligible health service** from a **network** or **out-of-network provider**
- You or your **provider precertifies** the **eligible health service** when required

You will find details on **medical necessity** and **precertification** requirements in the *Medical necessity and precertification requirements* section. You will find the requirement to use a **network provider** and any exceptions in the *Who provides the care* section.

4. Paying for eligible health services– sharing the expense

Generally your plan and you will share the expense of your **eligible health services** when you meet the general requirements for paying.

But sometimes your plan will pay the entire expense; and sometimes you will. For more information see the *What the plan pays and what you pay* section, and see the schedule of benefits.

5. Disagreements

We know that people sometimes see things differently.

The plan tells you how we will work through our differences. And if we still disagree, an independent group of experts called an "independent review organization" or IRO for short will sometimes make the final decision for us.

For more information see the *When you disagree - claim decisions and appeals procedures* section.

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

You have coverage when you want to get your care from **providers** who are not part of our network and network **providers** without a **primary care physician (PCP) referral**. It's called out-of-network coverage.

Your out-of-network coverage:

- Means you can get care from **providers** who are not part of our network.
- Means you may have to pay for services at the time they are provided. You may be required to pay the full charges and submit a claim for reimbursement to us. You are responsible for completing and submitting claim forms for reimbursement of **eligible health services** that you paid directly to a **provider**.
- Means that when you use out-of-network coverage, it is your responsibility to start the **precertification** process with **providers**.
- Means you will pay a higher cost share when you use an **out-of-network provider**.

You will find details on:

- **Precertification** requirements in the *Medical necessity and precertification requirements* section.
- Out-of-network **providers** and any exceptions in the *Who provides the care* section.
- Cost sharing in the *What the plan pays and what you pay* section, and your schedule of benefits.
- Claim information in the *When you disagree - claim decisions and appeals procedures* section.

How to contact us for help

We are here to answer your questions. You can contact us by:

- Logging onto your secure member website at www.innovationhealth.com.
- Register for our secure Internet access to reliable health information, tools and resources.
- Online tools will make it easier for you to make informed decisions about your health care, view claims, research care and treatment options, and access information on health and wellness.
-

You can also contact us by:

- Calling Member Services at the toll-free number on your ID card
- Writing us at **Innovation Health Insurance Company**, 3190 Fairview Park Drive, 5th Floor, Suite 570, Falls Church, VA 22042

You can also contact:

- The Virginia State Corporation Commission's Bureau of Insurance (BOI) at:
  Bureau of Insurance
  P.O. Box 1157
  Richmond, Virginia 23218-1157

  (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.

- The Office of Licensure and Certification of the Virginia Department of Health at: (800) 955-1819

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

Your member ID card

Your member ID card tells doctors, **hospitals**, and other **providers** that you are covered by this plan. Show your ID card each time you get health care from a **provider** to help them bill us correctly and help us better process their claims.

Remember, only you and your covered dependents can use your member ID card. If you misuse your card we may end your coverage.

We will mail you your ID card. If you haven't received it before you need **eligible health services**, or if you've lost it, you can print a temporary ID card. Just log into your secure member website at www.innovationhealth.com.

About us

Innovation Health Insurance Company is 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 32.1 of the Code of Virginia.

Who the plan covers

You will find information in this section about:

- Who is eligible
- When you can join the plan
- Who can be on your plan (who can be your dependent)
- Adding new dependents
- Special times you can join the plan

Who is eligible

Your employer decides and tells us who is eligible for health care coverage.

When you can join the plan

As an employee you can enroll:

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

If you do not enroll when you first qualify for health benefits, you may have to wait until the next annual enrollment period to join.

Who can be on your plan (who can be your dependent)

You can enroll the following family members on your plan. (They are your "dependents".)

- Your spouse
- Your domestic partner
    - You and your domestic partner will need to complete and sign a Declaration of Domestic Partnership. Contact your employer for the form. Or your domestic partner must meet the following criteria:
        - Be your sole domestic partner and intend to remain so indefinitely
        - Not be married or legally separated from anyone else
        - Be legally old enough to be in a domestic partnership in your state of residence
        - Not a blood relative to a degree of closeness that would prohibit legal marriage in the state in which you legally reside
        - Have lived together and resided in the same residence and intends to do this indefinitely
        - Is engaged with you in a committed relationship of mutual caring and support, and is jointly responsible for your common welfare and living expenses
        - Not in the relationship solely for the purpose of obtaining the benefits of coverage
        - Can submit proof of the relationship with at least three of the following:
            - Common ownership of a motor vehicle
            - Driver's license with a common address
            - Proof of joint bank accounts or credit accounts

        - Proof of designation as the primary beneficiary for life insurance or retirement benefits or primary beneficiary designation under your will
        - Assignment of a durable property power of attorney or health care power of attorney
- Your dependent children – your own or those of your spouse or domestic partner
- The children must be under 26 years of age and they include:
    - Your biological children
    - Stepchildren
    - Legally adopted children
    - Foster children, including any children placed with you for adoption
    - Any children you are responsible for under a qualified medical support order or court-order (whether or not the child resides with you)
    - Grandchildren in your court-ordered custody
    - A grandchild when his/her parent is a covered dependent under this plan
    - Any other child with whom you have a parent-child relationship

Effective date of coverage

Your coverage will be in effect at 12:01 am on the member effective date. Dependent coverage will be in effect on the member effective date, if you enrolled them at that time, otherwise, the first day of the first calendar month following receipt of the completed enrollment application.

Important note: You may continue coverage for a disabled child past the age limit shown above. See *Continuation of coverage for other reasons* in the *Special coverage options after your plan coverage ends* section for more information.

You can't have coverage as an employee and a dependent and you can't be covered as a dependent of more than one employee on the plan.

Adding new dependents

You can add the following new dependents any time during the year:

- A spouse - If you marry, you can put your spouse on your plan.
    - We must receive your completed enrollment information not more than 31 days after the date of your marriage.
    - Ask your employer when benefits for your spouse will begin:
        - If we receive your completed enrollment information by the 15th of the month, coverage will be effective no later than the first day of the following month.
        - If we receive your completed enrollment information between the 16th and the last day of the month, coverage will be effective no later than the first day of the second month.
- A domestic partner - If you enter a domestic partnership, you can enroll your domestic partner on your plan. See *Who can be on your plan (Who can be a dependent)* section for more information.
    - We must receive your completed enrollment information not more than 31 days after the date you file a Declaration of Domestic Partnership, or not later than 31 days after you provide documentation required by your employer.

  - Ask your employer when benefits for your domestic partner will begin. It will be on the date your Declaration of Domestic Partnership is filed or the first day of the month following the qualifying event date.
- A newborn child or grandchild - Your newborn child or grandchild is covered on your health plan for the first 31 days after birth.
  - To keep your newborn covered, we must receive your completed enrollment information within 60 days of birth.
  - You must still enroll the child within 60 days of birth even when coverage does not require payment of an additional **premium** contribution for the covered dependent.
  - If you miss this deadline, your newborn will not have health benefits after the first 31 days.
- An adopted child - See *Who can be on your plan (Who can be a dependent)* section for more information. An adopted child is covered on your plan for the first 31 days after the adoption is complete or the date the child is placed for adoption. "Placed for adoption" means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child.
  - To keep your adopted child covered, we must receive your completed enrollment information within 60 days after the adoption or the date the child was placed for adoption.
  - If you miss this deadline, your adopted child will not have health benefits after the first 31 days.
- A foster child – A foster child is covered on your plan for the first 31 days after obtaining legal responsibility as a foster parent. A foster child is a child whose care, comfort, education and upbringing is left to persons other than the natural parents.
  - To keep your foster child covered, we must receive your completed enrollment information within 60 days after the date the child is placed with you.
  - If you miss this deadline, your foster child will not have health benefits after the first 31 days.
- A stepchild - You may put a child of your spouse or domestic partner on your plan.
  - You must complete your enrollment information and send it to us within 31 days after the date of your marriage or declaration of domestic partnership with your stepchild's parent.
  - Ask your employer when benefits for your stepchild will begin. It is the date of your marriage or declaration of domestic partnership or the first day of the month following the qualifying event date.

Inform us of any changes

It is important that you inform us of any changes that might affect your benefit status. This will help us effectively deliver your benefits. Please contact us as soon as possible with changes such as:

- Change of address or phone number
- Change in marital status
- Change of covered dependent status
- A covered dependent who enrolls in Medicare or any other group health plan

Special times you can join the plan

Federal law allows you and your dependents to enroll at times other than your employer's annual open enrollment period. This is called a special or limited enrollment period.
You can enroll in these situations when:

- You have lost minimum essential coverage.
- You have added a dependent because of marriage, birth, adoption or foster care. See the *Adding new dependents* section for more information.
- You are now eligible or not eligible for the premium tax credit or change in eligibility for cost share reduction, for marketplace coverage.
- You have access to new plans because you have moved to a new permanent location.
- You become a citizen, national or lawfully present in the United States.
- You did not enroll in this plan before because:
  - You were covered by another group health plan, and now that other coverage has ended.
  - You had COBRA, and now that coverage has ended.
- A court orders you cover a current spouse or a child on your health plan.
- You lose your eligibility for enrollment in Medicaid or an S-CHIP plan
- You become eligible for State **premium** assistance under Medicaid or an S-CHIP plan for the payment of your **premium** contribution for coverage under this plan.

We must receive your completed enrollment information from you within 60 days of the event or the date on which you no longer have the other coverage mentioned above.

Effective date of coverage

Your coverage will be in effect on the first date of the month based on when we receive your completed enrollment application.

Medical necessity and precertification requirements

The starting point for **covered benefits** under your plan is whether the services and supplies are **eligible health services.** See the *Eligible health services under your plan* and *Exceptions* sections plus the schedule of benefits.

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

- The **eligible health service** is **medically necessary**.
- You or your **provider precertifies** the **eligible health 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 produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

This section addresses the **medical necessity** and **precertification** requirements. You will find the requirement to use a **network provider** and any exceptions in the *Who provides the care* section.

Medically necessary; medical necessity

As we said in the *Let's get started!* section, **medical necessity** is a requirement for you to receive **eligible health services** under this plan.

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

Precertification

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

In-network: Your **physician** or **PCP** is responsible for obtaining any necessary **precertification** before you get the care. If your **physician** or **PCP** doesn't get a required **precertification**, we won't pay the **provider** who gives you the care. You won't have to pay either if your **physician** or **PCP** fails to ask us for **precertification**. If your **physician** requests **precertification** and we refuse it, you can still get the care but the plan won't pay for it. You will find details on requirements in the *What the plan pays and what you pay - Important exceptions – when you pay all* section.

Out-of-network: When you go to an **out-of-network provider**, you are responsible to obtain **precertification** from us for any services and supplies on the **precertification** list. If you do not **precertify**, your benefits may be reduced, or the plan may not pay. See your schedule of benefits for this information. The list of services and supplies that require **precertification** appears later in this section. Also, for any **precertification** benefit reduction that is applied, see the schedule of benefits *Precertification benefit reduction* section.

You should get **precertification** within the timeframes listed below. To obtain **precertification**, call us at the telephone number listed on your ID card. This call must be made:

	You, your **physician** or the facility will:
For non-emergency admissions	Call and request **precertification** at least 14 days before the date you are scheduled to be admitted.
For an **emergency medical condition**	Call prior to the outpatient care, treatment or procedure or as soon as reasonably possible.
For an **emergency admission**	Call within 48 hours or as soon as reasonably possible after you have been admitted.
For an **urgent admission**	Call before you are scheduled to be admitted. 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 an **injury**.
For outpatient non-emergency medical services requiring **precertification**	Call at least 14 days before the outpatient care is provided, or the treatment or procedure is scheduled.

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

When you have 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 your **stay** be extended, additional days will need to be **precertified**. You, your **physician**, or the facility will need to call us at the number on your ID card as soon as reasonably possible, but no later than the final authorized day. We will review and process the request for an extended **stay**. We will tell you and your **physician** in writing of an approval or denial.

If **precertification** determines that the **stay** or services and supplies are not **covered benefits**, we will explain why and how our decision can be appealed. You or your **provider** may request a review of the **precertification** decision. See the *When you disagree - claim decisions and appeals procedures* section.

What if you don't obtain the required precertification?

If you don't obtain the required **precertification**:

- Your benefits may be reduced, or the plan may not pay any benefits. See the schedule of benefits *Precertification benefit reduction* section.
- You will be responsible for the unpaid balance of the bills.
- Any additional out-of-pocket expenses incurred will not count toward your out-of-network **deductible** or **maximum out-of-pocket limit** if there are any.

What types of services require precertification?

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

Inpatient services and supplies	**Outpatient services and supplies**
Stays in a **hospital**	Complex imaging
Stays in a **skilled nursing facility**	**Cosmetic** and reconstructive **surgery**
Stays in a **rehabilitation facility**	Injectables, (immunoglobulins, growth hormones, Multiple Sclerosis medications, Osteoporosis medications, Botox, Hepatitis C medications)
Stays in a **hospice** facility	Kidney dialysis
Stays in a **residential treatment facility** for treatment of **mental disorders** and **substance use disorder**	Outpatient back surgery not performed in a **physician's** office
Bariatric (obesity) surgery	Private duty nursing services
	Sleep studies
	Knee **surgery**
	Wrist **surgery**

How can I request a medical exception?

Sometimes you or your **prescriber** may ask for a medical exception to get health care services for **prescription drugs** that are not covered under this plan or for which health care services are denied through **precertification** or **step therapy**. You or your **prescriber** can contact us. You will need to provide us with the required clinical documentation. We will make a coverage determination within 72 hours after we receive your request and any information and will tell you and your **prescriber** of our decision. Any exception granted is based upon an individual, case by case decision, and will not apply to other members. If approved by us, you will receive the non-preferred benefit level and the exception will apply for the entire time of the **prescription**.

You, someone who represents you or your **prescriber** may seek a quicker medical exception process to get coverage for non-covered drugs in an urgent situation. An urgent situation happens when you have a health condition that may seriously affect your life, health, or ability to get back maximum function or when you are going through a current course of treatment using a **non-preferred drug**. You, someone who represents you or your **prescriber** may submit a request for a quicker review for an urgent situation by:

- Contacting our Precertification Department at 1-855-582-2025
- Faxing the request to 1-855-330-1716
- Submitting the request in writing to CVS Health ATTN: **Innovation Health**, 1300 E Campbell Road Richardson, TX 75081

We will make a coverage determination within 24 hours after we receive your request and will tell you, someone who represents you and your **prescriber** of our decision. If approved by us, the exception will apply for the entire time you have an urgent situation.

If you are denied a medical exception based on the above processes, you may have the right to a third party review by an independent external review organization. If our claim 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 also will describe the external review process. We will tell you, someone who represents you or your **prescriber** of the coverage determination of the external review no later than 72 hours after we receive your request. If the medical exception is approved, coverage will be provided for the entire time of the prescription. For quicker medical exceptions in urgent situations, we will tell you, someone who represents you or your **prescriber** of the coverage determination no later than 24 hours after we receive your request. If the quicker medical exception is approved, coverage will be provided for the entire time you have an urgent situation.

Eligible health services under your plan

The information in this section is the first step to understanding your plan's **eligible health services**. If you have questions about this section, see the *How to contact us for help* section.

Your plan covers many kinds of health care services and supplies, such as **physician** care and **hospital stays**. But sometimes those services are not covered at all or are covered only up to a limit.

For example:

- **Physician** care generally is covered but **physician** care for **cosmetic** surgery is never covered. This is an exclusion.
- Home health care is generally covered but it is a **covered benefit** only up to a set number of visits a year. This is a limitation.

You can find out about exclusions in the *Exceptions* section, and about the limitations in the schedule of benefits.

We've grouped the **eligible health services** below to make it easier for you to find what you're looking for.

1. Preventive care and wellness

This section describes the **eligible health services** and supplies available under your plan when you are well.

Important notes:

1. You will see references to the following recommendations and guidelines in this section:
   - Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
   - United States Preventive Services Task Force
   - Health Resources and Services Administration
   - American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents

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

2. Diagnostic testing is not covered under the preventive care benefit. You will pay the cost sharing specific to **eligible health services** for diagnostic testing.

3. Gender-specific preventive care benefits include any **eligible health services** described below regardless of the sex you were assigned at birth, your gender identity, or your recorded gender.

4. To learn what frequency and age limits apply to routine physical exams and routine cancer screenings, contact your **physician** or see the *How to contact us for help* section. This information can also be found at the www.healthcare.gov website.

Routine physical exams

Eligible health services include office visits to your **physician**, **PCP** or other **health professional** for routine physical exams. This includes routine vision and hearing screenings given as part of the exam.

A routine exam is a medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified **illness** or **injury**, and it 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
    - Screening for gestational diabetes for women
    - High risk Human Papillomavirus (HPV) DNA testing for women age 30 and older and limited to once every 3 years
- Radiological services, lab and other tests given in connection with the exam
- For covered newborns, an initial **hospital** checkup
- Infant hearing screenings and all necessary audiological examinations provided in a hospital. The infant hearing screenings and audiological exams must use U. S. Food and Drug Administration (FDA) approved technology that is recommended by the Joint Committee on Infant Hearing in its most current position statement addressing early hearing detection and intervention programs
- Follow-up audiological examinations as recommended by the infant's **physician** or audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss
- For infants, children and adolescents assessments for alcohol and drug use, behavioral, oral health risk; medical history; BMI measurements; screenings for autism (18 and 24months), blood pressure, cervical dysplasia, depression, development, dyslipidemia, hematocrit or hemoglobin, Hepatitis, B, HIV, lead, obesity, sexually transmitted infection (STI), tuberculin, and vision. Also includes counseling for obesity and STI, and supplements for fluoride chemoprevention and iron.
- For adults screening for abdominal aortic aneurysm, alcohol misuse, colorectal cancer, high blood pressure, Type 2 Diabetes, cholesterol, depression, Hepatitis B and C, HIV, lung cancer, obesity, syphilis, and tobacco use. Also includes counseling for alcohol misuse, nutrition, obesity, sexually transmitted infection prevention, and smoking and tobacco cessation products, including nicotine patches and gum when obtained with a prescription. Covers aspirin use to prevent cardiovascular disease.

For a detailed listing of preventive care services described in this section refer to https://www.healthcare.gov/prevention/.

Preventive care immunizations

Eligible health services include immunizations for children, adolescents, and adults provided by your **physician** for infectious diseases recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

Your plan does not cover immunizations that are not considered preventive care, such as those required due to your employment or travel.

Well woman preventive visits

Eligible health services include your routine:

- Well woman preventive exam office visit to your **physician**, **PCP** obstetrician (OB), gynecologist (GYN) or OB/GYN. This includes cervical cancer screenings (Pap smear) and testing using any FDA approved gynecologic cytology screening technologies. Your plan covers the exams recommended by the Health Resources and Services Administration. 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**.
- Osteoporosis screening
- Preventive care breast cancer (BRCA) gene blood testing by a **physician** and lab.
- Preventive breast cancer genetic counseling provided by a genetic counselor to interpret the test results and evaluate treatment.
- Breast cancer chemoprevention

Preventive screening and counseling services

Eligible health services include screening and counseling by your **health professional** for some conditions. These are obesity, misuse of alcohol and/or drugs, use of tobacco products, sexually transmitted infection counseling and genetic risk counseling for breast and ovarian cancer. Your plan will cover the services you get in an individual or group setting. Here is more detail about those benefits.

- **Obesity and/or healthy diet counseling**
  Eligible health services include the following screening and counseling services to aid in weight reduction due to obesity:
  - Preventive counseling visits and/or risk factor reduction intervention
  - Nutritional counseling
  - Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease

- **Misuse of alcohol and/or drugs**
  Eligible health services include the following screening and counseling services to help prevent or reduce the use of an alcohol agent or controlled substance:
  - Preventive counseling visits
  - Risk factor reduction intervention
  - A structured assessment

- **Use of tobacco products**
  Eligible health services include the following screening and counseling services to help you to stop the use of tobacco products:
  - Preventive counseling visits
  - Treatment visits
  - Class visits

  Tobacco product means a substance containing tobacco or nicotine such as:
  - Cigarettes
  - Cigars
  - Smoking tobacco
  - Snuff
  - Smokeless tobacco
  - Candy-like products that contain tobacco

- **Sexually transmitted infection counseling**
  Eligible health services include the counseling services to help you prevent or reduce sexually transmitted infections.

- **Genetic risk counseling for breast and ovarian cancer**
  Eligible health services include the counseling and evaluation services to help you assess whether or not you are at increased risk for breast and ovarian cancer.

Routine cancer screenings

Eligible health services include the following routine cancer screenings:

- Diagnostic mammogram
- Screening mammograms
  - age 35 to 39, one baseline
  - age 40 and older, one a year
- Prostate specific antigen (PSA) tests
- Digital rectal exams
- Fecal occult blood tests
- Sigmoidoscopies
- Double contrast barium enemas (DCBE)
- Colonoscopies which includes removal of polyps performed during a screening procedure and a pathology exam on any removed polyp
- Lung cancer screenings

Diagnostic examinations, and one digital rectal examination and prostate specific antigen (PSA) test in a 12-month period are covered for individuals age 50 and over and individuals age 40 and over who are at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society (ACS).

Colorectal cancer screening, specifically screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging are provided in accordance with the most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for ages, family histories and frequencies referenced in such recommendations.

These benefits will be subject to any age, family history and frequency guidelines that are:

- Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force
- Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration

If you need a routine GYN exam performed as part of a cancer screening, you may go directly to a network OB, GYN or OB/GYN.

Prenatal care

Eligible health services include your routine prenatal physical exams as preventive care, which includes the initial and subsequent physical exam services such as:

- Maternal weight
- Blood pressure
- Fetal heart rate check
- Fundal height
- Anemia screening
- Chlamydia infection screening
- Hepatitis B screening
- Rh incompatibility screening
- Gestational diabetes screening
- Urinary tract or screening for other infection
- Expanded tobacco intervention and counseling for pregnant users
- Prenatal screenings-
    - fetal screenings for genetic and/or chromosomal status of fetus
    - Anatomical, biochemical, or biophysical tests to better define likelihood of genetic and/or chromosomal anomalies.

You can get this care at your **physician's**, **PCP's**, OB's, GYN's, or OB/GYN's office.

Important note:
You should review the benefit under the *Eligible health services under your plan - Maternity and related newborn care* and *Exceptions* sections of this booklet-certificate for more information on coverage for pregnancy expenses under this plan.

Comprehensive lactation support and counseling services

Eligible health services include comprehensive lactation support (help and training in breast feeding) and counseling services during pregnancy or at any time following delivery for breast-feeding. Your plan will cover this when you get it in an individual or group setting. Your plan will cover this counseling only when you get it from a certified lactation support **provider**.

Breast feeding durable medical equipment

Eligible health services include renting or buying **durable medical equipment** you need to pump and store breast milk as follows:

Breast pump

Eligible health services include:

- Renting a **hospital** grade electric pump while your newborn child is confined in a **hospital**.
- The buying of:
  - An electric breast pump (non-**hospital** grade). Your plan will cover this cost once every three years, or
  - A manual breast pump. Your plan will cover this cost once per **plan year**.

If an electric breast pump was purchased within the previous three year period, the purchase of another electric breast pump will not be covered until a three year period has elapsed since the last purchase or if the initial electric breast pump is broken and no longer covered under a warranty.

Breast pump supplies and accessories

Eligible health services include breast pump supplies and accessories. These are limited to only one purchase per pregnancy in any year where a covered female would not qualify for the purchase of a new pump.

Coverage for the purchase of breast pump equipment is limited to one item of equipment, for the same or similar purpose. It also includes 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.

Family planning services – female contraceptives counseling, devices and voluntary sterilization

Eligible health services include family planning services such as:

Counseling services

Eligible health services include counseling services provided by a **physician**, **PCP**, OB, GYN, or OB/GYN on contraceptive methods. These will be covered when you get them in either a group or individual setting.

Devices

Eligible health services include contraceptive devices (including any related services or supplies) when they are provided by, administered or removed by a **physician** during an office visit.

Voluntary sterilization

Eligible health services include charges for female voluntary sterilization procedures and related services and supplies. This also could include tubal ligation and sterilization implants.

Important note:
See the following sections for more information:

- *Family planning services - other*
- *Maternity and related newborn care*
- *Outpatient prescription drugs - preventive contraceptives*
- *Treatment of basic infertility*

2. Physicians and other health professionals

Physician services

Eligible health services include medical care from a **physician**, **PCP**, specialist, nurse or physician assistant to examine, diagnose, and treat an **illness** or **injury** or provide a second opinion. You can get those services:

- At the **physician's** office
- In your home
- In a hospital
- From any other inpatient or outpatient facility
- By way of **telemedicine**
- Online medical visit with the **physician** using the internet by a webcam, chat or voice.

Other services and supplies that your **physician** may provide in the above listed settings:

- Allergy testing and treatment including allergy shots and allergy serum
- Injectable drugs
- Charges made by the **physician** for supplies, radiological services, x-rays, and tests provided by the **physician**
- **Medically necessary** treatment of varicose veins
- Surgery performed in a **physician**'s office
- Radiological supplies, services, and tests
- Chronic disease management

Physician surgical services

Eligible health services include the services of:

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

Alternatives to physician office visits

Walk-in clinic

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

- Unscheduled, non-medical emergency **illnesses** and **injuries**
- The administration of immunizations administered within the scope of the clinic's license
- Individual screening and counseling services that will help you:
  - In weight reduction due to obesity and/or healthy diet
  - To stop the use of tobacco products

Telemedicine Services

Eligible health services include charges for diagnosis, consultation, or treatment of health care services that are covered under this policy and are appropriately provided through **telemedicine** services.

3. Hospital and other facility care

Hospital care

Eligible health services include inpatient and outpatient **hospital** care for an illness, injury or pregnancy.

The types of **hospital** care services that are eligible for coverage include:

- **Room and board** charges up to the **hospital's semi-private room rate**. Your policy will cover the extra expense of a private room when appropriate because of your medical condition.
- Services of **physicians, surgeons or nurses** employed by the **hospital.**
- Operating and recovery rooms including pre- and post-operative care.
- Intensive or special care units of a **hospital.**
- Anesthesia and services rendered by an anesthesiologist.
- Administration of blood and blood derivatives and the cost of the blood or blood product.
- Radiation therapy.
- Rehabilitation and habilitation services and devices including speech therapy, physical therapy and occupational therapy.
- Oxygen and oxygen therapy.
- Radiological services, laboratory testing and diagnostic services including invasive procedures such as:
    - Angiogram
    - Arteriogram
    - Amniocentesis
    - Tap or puncture of the brain or spine
    - Endoscopic exams (arthroscopy, bronchoscopy, colonoscopy, laparoscopy)
- Nuclear medicine.
- Medications and injectable drugs.
- Intravenous (IV) preparations.
- Medical and surgical supplies (hypodermic needles, syringes surgical dressings, splints etc.)
- Sleep studies, sleep testing and sleep disorder treatments.
- Treatment of fractures and dislocations
- Infusion services.
- Discharge planning.
- Services and supplies provided by the outpatient department of a **hospital.**
- Laparoscopy-assisted vaginal hysterectomy or vaginal hysterectomy. **Eligible health services** also include:
    - A minimum stay of not less than 23 hours following a laparoscopy-assisted vaginal hysterectomy
    - A minimum stay of not less than 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.

Alternatives to hospital stays

Outpatient surgery

Eligible health services include services provided and supplies listed above that are used in connection with outpatient **surgery** performed in a **surgery center** or a **hospital's** outpatient department.

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

Home health care

Eligible health services include intermittent home health care 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 **skilled nursing facility**, or need to receive the same services outside your home.
- The services are part of a **home health care plan**.
- The services are **skilled nursing services**, home health aide services, diagnostic and social services, nutritional guidance, training, medical supplies, durable medical equipment medical or 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**.

Home health services include visits by licensed health care professionals, including a

- Nurse
- Therapist
- Home health aide

Physical, speech and occupational therapy services provided in the home are not subject to the conditions and limitations imposed on therapy provided outside the home. See the *Rehabilitation services* and *Habilitation therapy services* sections and the schedule of benefits.

Home health care services do not include **custodial care** or applied behavior analysis.

Hospice care

Eligible health services include inpatient and outpatient **hospice care** when given as part of a **hospice care program**.

The types of hospice care services that are eligible for coverage include:

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

Hospice care services provided by the **providers** below may 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
- An R.N. or L.P.N.
- A physical, speech or occupational therapist
- A **home health care agency** for:
  - Physical, speech and occupational therapy
  - Home health aide and homemaker services
  - Durable medical equipment
  - Medical supplies
  - Outpatient **prescription drugs**
  - Infusion services
  - Routine lab services
  - Psychological counseling
  - Dietary counseling

Physical, speech and occupational therapy provided under the hospice benefit are not subject to any visit limits.

Skilled nursing care

Eligible health services include inpatient and outpatient services provided by an **R**.**N**., **L**.**P**.**N**., or nursing agency for inpatient and outpatient skilled nursing care. This is care by a visiting **R**.**N**., or **L**.**P**.**N**. to perform specific skilled nursing tasks.

Your plan also covers private duty nursing provided by an **R**.**N**. or **L**.**P**.**N**. for non-hospitalized acute **illness** or **injury** if your condition requires skilled nursing care and visiting nursing care is not adequate.

Skilled nursing facility

Eligible health services include inpatient **skilled nursing facility** care.

The types of **skilled nursing facility** care services that are eligible for coverage include:

- **Room and board**, up to the **semi-private room rate**
- Medical and general nursing services that are provided during your **stay** in a **skilled nursing facility**
- Radiological services and lab work
- Physical, occupational, or speech therapy
- Oxygen and other gas therapy
- Drugs and biologicals
- Rehabilitative services
- Medical supplies

For your **stay** in a **skilled nursing facility** to be eligible for coverage, the following conditions must be met:

- The **skilled nursing facility** admission will take the place of:
  - An admission to a **hospital** or sub-acute facility.
  - A continued **stay** in a **hospital** or sub-acute facility.
- There is a reasonable expectation that your condition will improve enough to go home within a reasonable amount of time.
- The **illness** or **injury** is severe enough to require constant or frequent skilled nursing care on a 24-hour basis.

4. Emergency services and urgent care

Eligible health services include services and supplies for the treatment of an **urgent condition** or **emergency services** and supplies for treatment of an **emergency medical condition**. **Eligible health services** include diagnostic x-ray, lab services, medical supplies, and advanced diagnostic imaging, such as MRIs and CAT scans to evaluate and stabilize a patient with an **emergency medical condition**.

Your coverage for **emergency services** and urgent care from **out-of-network providers** ends when your condition is stabilized and the attending **physician** and we determine that you are medically able to travel or to be transported to a **network provider** if you need more care.

Follow-up care must be provided by your **physician, PCP** or **specialist**. See the *Medical necessity and precertification requirements* section for more information. If you use an **out-of-network provider** to receive follow up care, you are subject to a higher out-of-pocket expense.

In case of a medical emergency

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 assistance. If possible, call your **physician**, but only if a delay will not harm your health.

Non-emergency condition

If you go to an emergency room for what is not an **emergency medical condition**, only the initial screening and stabilization will be covered. See the schedule of benefits and the *Exception* and *Glossary* sections for specific information.

In case of an urgent condition

Urgent condition

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**.

Non-urgent care

If you go to an **urgent care facility** for what is not an **urgent condition,** the plan may not cover your expenses. See the *Exceptions* section and the schedule of benefits for specific plan details.

5. Dental care

Pediatric dental care

Eligible health services include dental services and supplies provided by a **dental provider**. The **eligible health services** are those listed in the pediatric dental care section of the schedule of benefits. . Coverage is limited to covered persons through the end of the month in which the person turns 19. We have grouped them as Type A, B and C, and orthodontic treatment services in the schedule of benefits.

Eligible health services also include dental services provided for a dental emergency. Services and supplies provided for a dental emergency will be covered even if services and supplies are provided by an **out-of- network provider**.

A dental emergency is any dental condition which:

- Occurs unexpectedly
- Requires immediate diagnosis and treatment in order to stabilize the condition
- Is characterized by symptoms such as severe pain and bleeding

If you have a dental emergency, you may get treatment from any dentist. You should consider calling your **dental provider** who may be more familiar with your dental needs. If you cannot reach your **dental provider** or are away from home, you may get treatment from any dentist. You may also call Member Services for help in finding a dentist. Services given for other than the temporary relief of the dental emergency by an **out-of-network provider** can cost you more. To get the maximum level of benefits, services should be provided by your network **dental provider**.

What rules and limits apply to dental care?

Several rules apply to the dental benefits. Following these rules will help you use the plan to your advantage by avoiding expenses that are not covered by the plan.

When does your plan cover orthodontic treatment?

Orthodontic treatment is covered for a severe, dysfunctional, disabling condition such as:

- Cleft lip and palate, cleft palate, or cleft lip with alveolar process involvement
- The following craniofacial anomalies:
  - Hemifacial microsomia
  - Craniosynostosis syndromes
  - Cleidocranial dental dysplasia
  - Arthrogryposis
  - Marfan syndrome
- Anomalies of facial bones and/or oral structures
- Facial trauma resulting in functional difficulties

If you suffer from one of these conditions, the orthodontic services that are eligible for coverage include:

- Pre-orthodontic treatment visit
- Comprehensive orthodontic treatment
- Orthodontic retention (removal of appliances, construction and placement of retainers(s)

When does your plan cover replacements?

Crowns, inlays, onlays and veneers, complete dentures, removable partial dentures, fixed partial dentures (bridges) and other prosthetic services are subject to the plan's “replacement rule”. The replacement rule is that certain replacements of, or additions to, existing crowns, inlays, onlays and veneers, dentures or bridges are covered only when you give us proof that:

- You had a tooth (or teeth) extracted after the existing denture or bridge was installed. As a result, you need to replace or add teeth to your denture or bridge.
- The present crown, inlay, onlay and veneer, complete denture, removable partial denture, fixed partial denture (bridge), or other prosthetic service was installed at least 5 years before its replacement and cannot be fixed.

- You had a tooth (or teeth) extracted. Your present denture is an immediate temporary one that replaces that tooth (or teeth). A permanent denture is needed, and the temporary denture cannot be used as a permanent denture. Replacement must occur within 12 months from the date that the temporary denture was installed.

When does your plan cover missing teeth that are not replaced?

The installation of complete dentures, removable partial dentures, fixed partial dentures (bridges), and other prosthetic services if:

- The dentures, bridges or other prosthetic items are needed to replace one or more natural teeth. (The extraction of a third molar tooth does not qualify.)
- The tooth that was removed was not an abutment to a removable or fixed partial denture installed during the prior 5 years.

Any such appliance or fixed bridge must include the replacement of an extracted tooth or teeth.

Adult dental care

Eligible health services include the following dental services and supplies provided by a **dental provider:**

- Preparing the mouth for medical services and treatments such as radiation therapy to treat cancer and preparing for transplants, including:
  - Evaluation
  - Dental x-rays
  - Extractions, including surgical extractions
  - Anesthesia
- Removing, repairing, restoring or repositioning natural teeth damaged or lost due to accidental **injury**, including
  - Dental work
  - Surgery
  - Dental appliances
  - Orthodontic treatment
- Repairing dental appliances damaged due to an accidental injury to the jaw, mouth, or face

6. Specific conditions

Anesthesia and hospital charges for dental care

Eligible health services include anesthesia and hospitalization or outpatient facility charges for dental care only if you:

- Have a disability or condition that requires that a dental procedure be done in a **hospital** or outpatient surgery center, or
- Are severely disabled, or
- Have a medical need for general anesthesia, or
- Are under 5 years old

Autism spectrum disorder

Autism spectrum disorder is defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association*.

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

We will cover early intensive behavioral interventions such as applied behavior analysis. Applied behavior analysis is an educational service that is the process of applying interventions:

- That systematically change behavior.
- That are responsible for observable improvements in behavior.

Important note: Applied behavioral analysis requires **precertification** by us**.** The **network provider** is responsible for obtaining **precertification**. You are responsible for obtaining **precertification** if you are using an **out-of-network provider**.

Bones or joints of the head, neck, face or jaw treatment

Eligible health services include medical care, diagnostic and surgical treatment for a medical condition or injury that prevents normal function of the bone or joint of the head, neck, face or jaw, including **jaw joint disorder,** temporomandibular and craniomandibular disorders, and removable appliances for TMJ repositioning.

Diabetic equipment, supplies and education

Eligible health services include:

- Services
  - Foot care to minimize the risk of infection (treatment of corns, calluses, and care of toenails)
- Supplies
  - Insulin
  - Diabetic needles and syringes
  - Injection aids for the blind
  - Diabetic test agents
  - Lancets/lancing devices

- Prescribed oral medications whose primary purpose is to influence blood sugar
- Alcohol swabs
- Dressings
- Injectable glucagons
- Glucagon emergency kits

Blood glucose test strips

- Equipment
  - External insulin pumps and pump supplies
  - Blood glucose monitors without special features, unless required due to blindness
- Training
  - In person self-management training and educational service, including medical nutrition therapy, provided by a certified, registered or licensed health care **provider**

This coverage is for the treatment of

- Insulin-dependent diabetes
- Insulin-using diabetes
- Gestational diabetes
- Non-insulin using diabetes

This coverage is for the treatment of insulin dependent (type I) and non-insulin dependent (type II) diabetes and the treatment of elevated blood glucose levels during pregnancy.

Family planning services – other

Eligible health services include certain family planning services provided by your **physician** such as:

- Voluntary sterilization for males
- Services to reverse a non-elective sterilization that resulted from an illness or injury
- Abortion (voluntary termination of pregnancy)

Maternity and related newborn care

Eligible health services include prenatal and postpartum care and obstetrical services provided by a **physician** or nurse midwife and facility. Pregnancy and childbirth services and supplies are covered at the same level as any **illness** or **injury** or with no cost share for **preventive** services (refer to the ***Eligible Health Services*** *Under Your Policy, Preventive Services section)*. **Eligible health services** include the following for both a member and any covered dependent:

- Pregnancy testing
- Prenatal and postnatal care services for pregnancy
  - Maternity-related check-ups
  - Treatment for complications of pregnancy
- Prenatal screenings
  - Fetal screenings for genetic and/or chromosomal status of the fetus
  - Anatomical, biochemical or biophysical tests, to better define the likelihood of genetic and/or chromosomal anomalies
- Delivery and all inpatient services for maternity care
  - Use of delivery room
  - Anesthesia
- Home delivery by a certified nurse midwife

After your child is born, **eligible health services** include:

- A minimum of 48 hours of inpatient care in a hospital after a vaginal delivery.
- A minimum of 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.
- Newborn nursery care
  - Hospital services for routine nursery care for the newborn during the mother's normal stay
  - Initial newborn exam
    - Behavioral assessments and measurement
    - Blood pressure
    - Hearing screening
    - hemoglobinopathies screening
    - gonorrhea prophylactic medication
    - hypothyroidism screening,
    - PKU screening
    - Rh incompatibility testing
  - circumcision of a covered male dependent
- Post-delivery home visits by a health care **provider** in accordance with the medical criteria, outlined in the most current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologist or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists.
- Care and treatment for the newborn to correct functional impairment caused by congenital defects and birth abnormalities including inpatient and outpatient dental, oral surgical, and orthodontic services that are medically necessary for the treatment of cleft lip, cleft palate or ectodermal dysplasia.

Mental health treatment

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

- **Inpatient room and board** at the **semi-private room rate**, and other services and supplies related to your condition provided during your **stay** in a **hospital**, **psychiatric hospital**, or **residential treatment facility**. Coverage includes:
  - Individual psychotherapy,
  - Group psychotherapy,
  - Psychological testing,
  - Counseling with family members to assist with the patient's diagnosis and treatment, and
  - Convulsive therapy treatment
- Outpatient treatment received while not confined as an inpatient in a **hospital**, **psychiatric hospital** or **residential treatment facility**
  - **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**.

- Outpatient visits to providers as may be necessary and appropriate for diagnosis and treatment of psychiatric conditions, including:
    - Psychological testing
    - Individual psychotherapy
    - Group psychotherapy
    - Counseling with family members to assist with patient's diagnosis and treatment
    - Convulsive therapy treatment
- Office visits to a **physician** or **behavioral health provider** such as a **psychiatrist**, psychologist, social worker, or licensed professional counsel or
- Other outpatient mental health treatment such as:
    - Electro-convulsive therapy (ECT).
    - Mental health injectables.

Eligible health services also include 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 needing to receive the same services outside your home.
- The services are part of an active treatment plan of care.
- The skilled behavioral health care is appropriate for the active treatment of a condition, **illness** or disease to avoid placing you at risk for serious complications.

Substance use disorder treatment

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

- Inpatient **room and board** at the **semi-private room rate** and other services and supplies provided during your **stay** in a **hospital**, psychiatric hospital or **residential treatment facility**, including:
    - Individual psychotherapy,
    - Group psychotherapy,
    - Psychological testing,
    - Counseling with family members to assist with patient's diagnosis and treatment,
    - Convulsive therapy treatment,
    - **Detoxification,**
    - Rehabilitation,
- **Hospital** and inpatient professional charges in any **hospital** or facility required by state law.

  Treatment of **substance use disorder** in a general medical **hospital** is only covered if you are admitted to the **hospital's** separate **substance use disorder** section or unit, unless you are admitted for the treatment of medical complications of **substance use disorder**.

As used here, “medical complications” include, but are not limited to, **detoxification**, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens and hepatitis.

- Outpatient treatment received while not confined as an inpatient in a **hospital**, psychiatric hospital or **residential treatment facility**, including:
  - **Partial hospitalization treatment** provided in a facility or program for treatment of **substance use disorder** provided under the direction of a **physician**.
  - **Intensive outpatient program** provided in a facility or program for treatment of **substance use disorder** provided under the direction of a **physician**.
  - Ambulatory **detoxification** which are outpatient services that monitor withdrawal from alcohol or other **substance use disorder**, including administration of medications.
  - Outpatient visits to providers as may be necessary and appropriate for diagnosis and treatment of psychiatric conditions, including:
    - Psychological testing
    - Individual psychotherapy
    - Group psychotherapy
  - Outpatient facility charges
  - Office visits and **physician** charges
  - Medication management visits to monitor and adjust drugs prescribed for a substance use disorder
  - Office visits to a **physician** or **behavioral health provider** such as a **psychiatrist**, psychologist, social worker, or licensed professional counselor
  - Other outpatient **substance use disorder** treatment such as:
    - Substance use disorder injectables.

Oral Surgery

Eligible health services include charges made by a physician, a dentist or hospital for:

- Maxillary or mandibular frenectomy when not related to a dental procedure
- Alveolectomy when related to tooth extraction
- Orthognathic surgery that is required to attain functional capacity of the affected part.
- Surgical services on the hard or soft tissue in the mouth when the main purpose is not to treat or help the teeth and their supporting structures
- Treatment of non-dental lesions, such as removal of tumors and biopsies.
- Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses
- Cleft lip
- Cleft palate
- Ectodermal dysplasia

Reconstructive surgery and supplies

Eligible health services include reconstructive **surgery** by your **physician, hospital** or **surgery center** for reconstructive **surgery** and related supplies provided 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 and physical therapy to treat complications of the mastectomy, including lymphedema. These can be done at the same time as the mastectomy or later. **Eligible health services** for reconstructive breast surgery include**:**
  - 48 hours of inpatient care following a radical or modified radical mastectomy
  - 24 hours of inpatient care after a total or partial mastectomy with lymph node dissection for treatment of breast cancer.
- Your **surgery** corrects an accidental **injury** including subsequent related or staged surgery**.**
- Your **surgery** is needed to improve a significant functional impairment of a body part.
- Your **surgery** corrects a birth defect or other significant deformity caused by illness, injury or a previous treatment. The **surgery** will be covered if:
  - The defect results in severe facial disfigurement or major functional impairment of a body part.
  - The purpose of the **surgery** is to improve function.

Transplant services

Eligible health services include organ, tissue and stem cell/bone marrow transplant services and transfusion and infusion services provided by a **physician** and **hospital** only when we **precertify** them. **Eligible health services** for both the living donor and member also include

- Acquisition
- Mobilization
- Harvesting
- Storage of organs or tissue
- Preparatory myeloablative therapy or reduced intensity preparative chemotherapy, radiation therapy, or a combination of these therapies

Organ and tissue means:

- Solid organ
- Hematopoietic stem cell
- Bone marrow, including autologous bone marrow transplants for breast cancer

Network of transplant specialist facilities

The amount you will pay for covered transplant services is based upon where you get transplant services. You can get transplant services from:

- An **Institutes of Excellence™ (IOE) facility** we designate to perform the transplant you need
- A non-**IOE facility**

The National Medical Excellence Program® will coordinate all solid organ and bone marrow transplants and other specialized care you need.

Treatment of infertility

Basic infertility

Eligible health services include basic **infertility** care, including seeing a **network provider** to diagnose the underlying medical cause of **infertility** and any **surgery** needed to treat the underlying medical cause of **infertility**.

7. Specific therapies and tests

Outpatient diagnostic testing

Diagnostic complex imaging services

Eligible health services include complex imaging services by a **provider**, including:

- Computed tomography (CT) scans
- Magnetic resonance imaging (MRI) including Magnetic resonance spectroscopy (MRS), Magnetic resonance venography (MRV) and Magnetic resonance angiogram (MRA)
- Computer Tomographic Angiography (CTA)
- Nuclear medicine imaging including Positron emission tomography (PET)/CT fusion scans
- Single photon Emissions computed tomography (SPECT) scans
- Nuclear cardiology
- QTC Bone Densitometry
- Diagnostic CT colonography
- Other outpatient diagnostic imaging service where the billed charge exceeds $500
- Professional services to read the scan

Complex imaging for preoperative testing is covered under this benefit.

Diagnostic lab work

Eligible health services include diagnostic lab services, and pathology and other tests, but only when you get them from a licensed lab. **Eligible health services** include professional services for test and lab interpretation.

Diagnostic radiological services

Eligible health services include radiological services (other than diagnostic complex imaging) only when you get them from a licensed radiological facility. **Eligible health services** include:

- X-ray
- Mammogram
- Ultrasound
- Nuclear medicine
- EEG
- Echocardiogram
- EKG
- Professional services for test lab interpretation and x-ray reading

Chemotherapy

Eligible health 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**. **Eligible health services** include chemical or biological antineoplastic agents administered as part of a doctor's visit, home care visit, or at an outpatient facility for treatment of an illness. The criteria for establishing cost sharing applicable to orally administered cancer treatment drugs and cancer chemotherapy drugs that are administered intravenously or by injection shall be consistently applied.

Outpatient infusion therapy

Eligible health services include infusion therapy you receive in an outpatient setting including but not limited to:

- A free-standing outpatient facility
- The outpatient department of a **hospital**
- A **physician** in his/her office
- A home care **provider** in your home

See the *How to contact us for help* section to learn how you can access the list of preferred infusion locations.

Infusion therapy is nursing, durable medical equipment and drug services that are delivered and administered to you through an I.V. including:

- Total Parenteral Nutrition (TPN)
- Enteral nutrition therapy
- Antibiotic therapy
- Pain care
- Chemotherapy
- Injections (intra-muscular, subcutaneous, continuous subcutaneous)

Certain infused medications may be covered under the outpatient **prescription drug** section. You can access the list of **specialty prescription drugs**. See the *How to contact us for help* section to determine if coverage is under the outpatient **prescription drug** section or this section.

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

Dialysis

Eligible health services to treat acute renal failure and chronic (end stage) renal disease in an inpatient, outpatient, office or home setting include:

- Hemodialysis
- Peritoneal dialysis
- Training for you and the person who will help you with home self-dialysis

Outpatient radiation therapy

Treatment of an illness by:

- X-ray
- Radium
- Radioactive isotopes

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

- Treatment
  - Teletherapy
  - Brachytherapy and intraoperative radiation
  - Photon or high energy particle sources

- Materials and supplies needed
- Administration
- Treatment planning

Specialty prescription drugs

Eligible health services include **specialty prescription drugs** when they are:

- Purchased by your **provider**
- Injected or infused by your **provider** in an outpatient setting such as:
  - A free-standing outpatient facility
  - The outpatient department of a **hospital**
  - A **physician** in his/her office
  - A home care **provider** in your home
- Listed on our **specialty prescription drug** list as covered under this booklet-certificate

You can access the list of **specialty prescription drugs**. See the *How to contact us for help* section to determine if coverage is under the outpatient **prescription drug** section or this section.

Certain infused medications may be covered under the outpatient **prescription drug** section. You can access the list of **specialty prescription drugs**. See the *How to contact us for help* section to determine if coverage is under the outpatient **prescription drug** section or this section.

When injectable or infused services and supplies are provided in your home, they will not count toward any applicable **home health care** limits.

Cardiac and pulmonary rehabilitation services

Eligible health services include the cardiac and pulmonary rehabilitation services listed below.

Cardiac rehabilitation

Cardiac rehabilitation is the process of restoring, maintaining, teaching or improving the physiological, psychological, social and vocational capabilities of patients with heart disease. **Eligible health 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**.

Eligible health services include:

- Medical evaluation
- Training
- Supervised exercise
- Psychosocial support

Pulmonary rehabilitation

Eligible health services include pulmonary rehabilitation services (respiratory therapy) as part your inpatient **hospital stay** if it is part of a treatment plan ordered by your **physician**.

A course of outpatient treatment may also be eligible for coverage if it's performed at a **hospital, skilled nursing facility**, or **physician's** office, and is part of a treatment plan ordered by your **physician**.

Eligible health services include:

- Introducing dry or moist gases into the lungs
- Nonpressurized inhalation treatment
- Intermittent positive pressure breathing treatment
- Air or oxygen, with or without nebulized medication
- Continuous positive pressure ventilation (CPAP)
- Continuous negative pressure ventilation (CNP)
- Chest percussion
- Therapeutic use of medical gases or aerosol drugs
- Equipment such as resuscitators, oxygen tents and incentive spirometers
- Broncho pulmonary drainage
- Breathing exercises

Rehabilitation and habilitation services

Rehabilitation services help you restore and in some cases, maintain capabilities lost due to disease, illness, injury, or in the case of speech therapy, loss additionally due to congenital anomaly or prior medical treatment.

Habilitation services help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age.

Eligible health services include rehabilitation and habilitation services your **physician** prescribes. 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**

Rehabilitation and habilitation services have to follow a specific treatment plan, ordered by your **physician**.

Outpatient rehabilitation and habilitation, physical, occupational, and speech therapy

Eligible health services include:

- Professional services
- Physical therapy to:
  - Relieve pain
  - Teach, keep, improve or restore physical functions lost as a result of an **illness**, **injury** or **surgical procedure**
  - Prevent disability after illness, injury or loss of limb
  - Treat Lymphedema

  Including:
  - Hydrotherapy
  - Heat
  - Physical agents
  - Bio-mechanical
  - Neuro physiological principles and devices

- Occupational therapy to:
  - Teach, keep, improve, develop or restore physical activities such as walking, eating, drinking, dressing, toileting, transferring from wheelchair to bed, and bathing. Occupational therapy does not include educational therapy, vocational rehabilitation or employment counseling.
- Speech therapy to:
  - Identify, assess, and treat speech function, language, speech impairment and swallowing disorders in children and adults.
  - Improve delays in speech function development caused by a birth defect.
  - Teach speech
  - Keep, learn or improve skills needed for daily living, such as therapy for a child who is not talking at the expected age.
  - Treat communication or swallowing difficulties to correct a speech impairment.
  - Develop communication or swallowing skills to correct a speech impairment.

  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.

Early intervention services

Eligible health service include speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices for children from birth up to age 3. **Eligible health services** include services that are:

- Certified by the Department of Behavioral Health and Developmental Services as eligible services under Part H of the Individuals with Disabilities Education Act; and
- Designed to attain or retain the capacity to function age appropriately within the child's environment or enhance functional ability without effecting a cure

No visit limit applies to occupational, physical or speech therapy services received under the Early Intervention Service benefit.

Spinal manipulation (Chiropractic / Osteopathic / Manipulation therapy)

Eligible health services include spinal manipulation to correct a muscular or skeletal problem. It includes rehabilitative and habilitative therapy to treat problems of the bones, joints, and the back and surrounding muscles, tendons and ligaments.

Your **provider** must establish or approve a treatment plan that details the treatment, and specifies frequency and duration.

8. Other services

Acupuncture

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

Ambulance service

Eligible health services include transport by professional ground **ambulance** services:

- To the first **hospital** to provide **emergency services**.
- From one **hospital** to another **hospital,** if the first **hospital** cannot provide the **emergency services** needed.
- From **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. Transport is 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 **medically necessary** treatment.

Your policy also covers emergency transportation to a **hospital** by fixed wing or rotary wing air transportation or by water **ambulance** services when your condition is unstable, and requires medical supervision and rapid transport.

Blood products and blood infusion equipment

Eligible health services include blood products and blood infusion equipment you need for home treatment of:

- Routine bleeding episodes associated with hemophilia
- Other congenital bleeding disorders

The home treatment program needs to be under the supervision of the state approved hemophilia treatment center.

Clinical trial therapies (experimental or investigational)

Eligible health services include coverage for "Routine Patient Costs” for an “approved clinical trial”.

An "approved clinical trial" is a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and the study or investigation is:

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

Clinical trials (routine patient costs)

Eligible health services include "routine patient costs" incurred by you 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, as those terms are defined in the federal Public Health Service Act, Section 2709.

"Routine patient cost" means all items and services consistent with the coverage provided under this policy that is typically covered for a qualified individual who is not enrolled in a clinical trial.

NOTE: This definition excludes the cost of:

- Services and supplies related to data collection and record keeping that is not used in the direct clinical management of the patient.
- Services that are clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- the cost of the investigational item, drug or device.

“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.

Durable medical equipment (DME)

Eligible health services include the expense of renting or buying **DME** and accessories you need to operate the item from a **DME** supplier. Your plan will cover either buying or renting the item, depending on which we think is more cost efficient. If you purchase **DME**, that purchase is only eligible for coverage if you need it for long-term use.

When we **precertify** it, we cover the instruction and appropriate services needed for a member to learn how to properly use the item.

Coverage includes:

- One item of **DME** for the same or similar purpose.
- Repairing **DME** due to normal wear and tear. It does not cover repairs needed because of misuse or abuse.
- A new **DME** item you need because your physical condition has changed. It also covers buying a new **DME** item to replace one that was damaged due to normal wear and tear, if it would be cheaper than repairing it or renting a similar item.
- Supplies and equipment needed for the use of the **DME**, for example, a battery for a powered wheelchair.

Covered **DME** includes the following items:

- Nebulizers
- Hospital-type beds
- Wheelchairs
- Traction equipment
- Walkers
- Crutches
- Home dialysis equipment and supplies
- Oxygen, and equipment to administer oxygen including oxygen concentrators and ventilators
- Urinary catheters and external urinary collection devices
- Leg braces, including attached or built-up shoes attached to the leg brace; molded therapeutic shoes for diabetics with peripheral vascular disease
- Arm, back and neck braces
- Head halters
- Catheters and related supplies
- Orthotics(braces, boots, splints), other than foot orthotics, including the cost of fitting, adjustment and repair
- Negative pressure wound therapy devices
- Cochlear implants

All maintenance and repairs that result from a misuse or abuse are your responsibility.

Lymphedema

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

- Equipment
- Supplies
- Complex decongestive therapy
- Outpatient self-management training and education by a licensed health care professional
- Gradient compression garments:
  - Require a **prescription**
  - Are custom-fit for you
  - Do not include disposable medical supplies such as over-the-counter compression or elastic knee-high or other stocking products

Nutritional supplements

Eligible health services include nutrition infusion in the home and special formulas ordered by a **physician** for the treatment of inborn errors of amino acid or organic acid metabolism, metabolic abnormality, or severe protein or soy allergies.

Prosthetic devices

Eligible health services include the provision and subsequent replacement of a prosthetic device that your **physician** orders and administers. But we cover it only if we approve the device in advance.

Prosthetic device means:

- An artificial device to replace, in whole or in part, a limb, or
- a medical device which replaces all or part of an internal body organ or an external body part lost or impaired as the result of disease, congenital defect or **injury**
- A breast prosthesis (internal or external) following a mastectomy
- Colostomy and needed ostomy supplies
- Restoration prosthesis (composite facial prosthesis)
- Wigs needed after cancer treatment

Component means:

- The materials and equipment needed to ensure the comfort and functioning of a prosthetic device.

Limb means:

- an arm
- a hand
- a leg
- a foot
- any portion of an arm, a hand, a leg, or a foot.

Coverage includes:

- Fittings and adjustments
- 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
- Instruction and other services (such as attachment or insertion) so you can properly use the device

Sleep Treatment

Eligible health services include devices and supplies, such as APAP, CPAP, BPAP and oral devices for sleep treatment. These services are subject to **medical necessity** reviews by us.

Vision care

Pediatric vision care

Routine vision exams

Eligible health services include a routine vision exam provided by an ophthalmologist or optometrist. The exam will include refraction and glaucoma testing.

Vision care services and supplies

Eligible health services include:

- Eyeglass frames, **prescription** lenses or **prescription** contact lenses
  - **Prescription** lenses include
    - Choice of glass or plastic,
    - All lens powers (single vision, bifocal, trifocal, lenticular and standard progressives),
    - Fashion and gradient tinting, oversized and glass-grey #3 **prescription** sunglass lenses.
    - Polycarbonate lenses are covered in full for children.
    - Scratch resistant coating

Ultraviolet protective coating

- Non-conventional **prescription** contact lenses that are required to correct visual acuity to 20/40 or better in the better eye and that correction cannot be obtained with conventional lenses
- Aphakic **prescription** lenses prescribed after cataract **surgery** has been performed
- Low vision services and supplies, including prescribed optical devices, such as high powered spectacles, magnifiers and telescopes.

This benefit is subject to an age limit as shown on the schedule of benefits.

In any one **plan year**, this benefit will cover either **prescription** lenses for eyeglass frames or **prescription** contact lenses, but not both.

Adult vision care

Routine vision exams

Eligible health services include a routine vision exam provided by an ophthalmologist or optometrist. The exam will include refraction and glaucoma testing.

Vision correction after Surgery or Accident

Eligible health services include prescribed eyeglasses or contact lenses only when required as a result of surgery, or for treatment of an accidental injury. Services for exams and replacement of these eyeglasses or contact lenses will be covered only if the **prescription** change is related to the surgery, illness or injury that required the original **prescription**. The purchase and fitting of eyeglasses or contact lenses are covered if they are:

- Prescribed to replace the human lens lost due to surgery or injury
- The initial pair of “pinhole” glasses that are prescribed for use after surgery for a detached retina; or
- Lenses are prescribed instead of surgery in the following situations:
  - Contact lenses are used for the treatment of infantile glaucoma
  - Corneal or scleral lenses are prescribed in connection with keratoconus
  - Scleral lenses are prescribed to retain moisture when normal tearing is not possible or not Adequate; or
  - Corneal or scleral lenses are required to reduce a corneal irregularity other than astigmatism

9. Outpatient prescription drugs

What you need to know about your outpatient prescription drug covered benefits

Read this section carefully so that you know:

- How to access **network pharmacies**
- How to access out-of-network **pharmacies**
- **Eligible health services** under your plan
- Other services
- What **precertification** requirements apply

Some **prescription drug**s may not be covered or coverage may be limited. This does not keep you from getting **prescription drug**s that are not **covered benefits**. You can still fill your **prescription**, but you have to pay for it yourself. For more information see the schedule of benefits.

A **pharmacy** may refuse to fill a **prescription** order or refill when in the professional judgment of the pharmacist the **prescription** should not be filled.

How to access network pharmacies

How do you find a network pharmacy?

You can find a **network pharmacy** online or by phone. See the *How to contact us for help* section for details.

How to access out-of-network pharmacies

You can directly access an out-of-network **pharmacy** to get covered outpatient **prescription drugs**.
If you use an out-of-network **pharmacy** to obtain outpatient **prescription drugs**, you are subject to a higher out-of-pocket expense and are responsible for:

- Paying your out-of-network outpatient **prescription drug deductible**
- Your out-of-network **coinsurance**
- Any charges over our **recognized charge**
- Submitting your own claims

Eligible health services under your plan

Eligible health services include any **pharmacy** service that meets these three requirements:

- They are listed in the *Eligible health services under your plan* section.
- They are not listed in the *Exceptions* section.
- They are not beyond any limits in the schedule of benefits.

Your pharmacy services are covered when you follow the plan's general rules:

- You need a **prescription** from your **prescriber**.
- Your drug needs to be **medically necessary**. See the *Medical necessity and precertification requirements* section.
- You need to show your ID card to the **pharmacy** when you get a **prescription** filled.

Your outpatient **prescription drug** plan is based on the plan elected and the drugs in the **preferred drug guide**. The **preferred drug guide** includes both **brand-name prescription drugs** and **generic prescription drugs**. Your out-of-pocket costs may be higher if your **prescriber** prescribes a **prescription drug** not listed in the **preferred drug guide**.

Generic prescription drugs may be substituted by your pharmacist for **brand-name prescription drugs**. Your out-of-pocket costs may be less if you use a **generic prescription drug** when available.

Eligible health services and supplies of **prescription drugs** may be subject to **precertification**, **step therapy** or our other requirements or limitations. **Prescription drugs** covered by this plan are subject to misuse, waste and/or abuse utilization review by us, your **prescriber** and/or your **network pharmacy**. The outcome of this review may include: limiting coverage of the applicable drug(s) to a single prescribing provider and/or **network pharmacy**, limiting the covered drug quantity/dosage.

Your **prescriber** may give you a **prescription** in different ways, including:

- Writing out a **prescription** that you then take to a **network pharmacy.**
- Calling or e-mailing a **network pharmacy** to order the medication.
- Submitting your **prescription** electronically.

Once you receive a **prescription** from your **prescriber**, you may fill the **prescription** at a **network retail**, **mail order** or **specialty pharmacy**.

Retail pharmacy

Generally, **retail pharmacies** may be used for up to a 30 day supply of **prescription drugs**. You should show your ID card to the **network pharmacy** every time you get a **prescription** filled. The **network pharmacy** will submit your claim online. You will pay any cost sharing directly to the **network pharmacy**.

You do not have to complete or submit claim forms. The **network pharmacy** will take care of claim submission.

All **prescriptions** and refills over a 30 day supply must be filled at a network **mail order pharmacy**.

Mail order pharmacy

For certain kinds of **prescription drugs**, you can use the plan's network **mail order pharmacy**. Generally, the drugs available through mail order are maintenance drugs that you take on a regular basis for a chronic or long-term medical condition.

Outpatient **prescription drugs** are covered when dispensed by a network **mail order pharmacy.** Each **prescription** is limited to a maximum 90 day supply. **Prescriptions** for less than a 30 day supply or more than a 90 day supply are not eligible for coverage when dispensed by a network **mail order pharmacy**.

Specialty pharmacy

Specialty prescription drugs are covered when dispensed through a **network specialty pharmacy**.

Specialty prescription drugs typically include high-cost drugs that require special handling, special storage or monitoring and include but are not limited to oral, topical, inhaled and injected ways of giving them. You can access the list of **specialty prescription drugs** and **biosimilar prescription drugs**. See the *How to contact us for help* section for how.

All **specialty prescription drugs** including the initial fill must be filled at a **specialty pharmacy**.

Specialty prescription drugs may fall under various drug tiers regardless of their names.
See the schedule of benefits for details on supply limits and cost sharing.

Other services

Preventive contraceptives

For females who are able to become pregnant, your outpatient **prescription drug** plan covers the services and supplies that the U.S. Food and Drug Administration (FDA) has approved to prevent pregnancy.

Eligible health services include the following when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing.

The following female contraceptives that are **generic prescription drugs**:

- Oral drugs
- Injectable drugs
- FDA approved contraceptive vaginal rings
- Transdermal contraceptive patches
- Female contraceptive devices and implants including the related services and supplies to administer the device
- FDA approved female generic emergency contraceptives
- FDA approved female generic over-the-counter emergency contraceptives
- Other FDA approved female generic over-the-counter (OTC) contraceptives
- Other FDA approved male generic over-the-counter (OTC) contraceptives

To the extent **generic prescription drugs** are not available, **brand-name prescription drugs** will be covered.

Injectables

Eligible health services include injectable drugs and injections administered at an authorized pharmacy, including flu shots and their administration.

Diabetic supplies

Eligible health services include but are not limited to the following diabetic supplies upon **prescription** by a **prescriber**:

- Diabetic needles and syringes
- Test strips for glucose monitoring and/or visual reading
- Diabetic test strips
- Lancets/lancing devices
- Alcohol swabs

See the *Specific conditions - Diabetic equipment, supplies and education* section for diabetic supplies that you can get from other **providers**.

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 symptom(s). Eligibility for coverage is subject to the following:

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

Health care services related to off-label use of these drugs may be subject to **precertification**, **step therapy** or other requirements or limitations.

Over-the-counter drugs

Eligible health services include certain over-the-counter medications, as determined by the plan, in the same **prescription** dosage strength for the appropriate member responsibility. Coverage of the selected over-the-counter medications requires a **prescription**. You can access the list by logging onto your secure member website at www.innovationhealth.com.

Preventive care drugs and supplements

Eligible health services include the following preventive care drugs and supplements (including over-the-counter drugs and supplements) when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing:

- Aspirin: Available to adults to prevent cardiovascular disease and preeclampsia in women.
- Oral fluoride supplements: Available to children whose primary water source is deficient in fluoride.
- Folic acid supplements: Available to adult females planning to become pregnant or capable of pregnancy.
- Iron supplements: Available to children without symptoms of iron deficiency but who are at an increased risk for iron deficiency anemia.
- Vitamin D supplements: Available to adults to promote calcium absorption and bone growth.

Risk reducing breast cancer prescription drugs

Eligible health services include **prescription drugs** when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing for a woman who is at:

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

Tobacco cessation prescription and over-the-counter drugs

Eligible health services include FDA approved **prescription drugs** and over-the-counter (OTC) drugs to help stop the use of tobacco products, when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing.

Where your schedule of benefits fits in

You are responsible for paying your part of the cost sharing. The schedule of benefits shows any benefit limitations and any out-of-pocket costs you are responsible for. Keep in mind that you are responsible for costs not covered under this plan.

Your **prescription drug** costs are based on:

- The type of **prescription** you use
- Where you fill your **prescription**

The plan may, in certain circumstances make some **preferred brand-name prescription drugs** available to members at the **generic copayment** level.

Precertification requirements apply

Why do some drugs need precertification?

For certain drugs, you, your **prescriber** or your pharmacist needs to get approval from us before we will agree to cover the drug for you. Sometimes the requirement for getting approval in advance helps guide appropriate use of certain drugs and makes sure there is a **medically necessary** need for the drug. For the most up-to-date information, call us or go online. See the *How to contact us for help* section for details.

There is another type of **precertification** for **prescription drugs**, and that is **step therapy**.

You will find the **step therapy prescription drugs** on the **preferred drug guide**. For the most up-to-date information, call us or go online. See the *How to contact us for help* section for details.

How can I request a medical exception?

Sometimes you or your **prescriber** may ask for a medical exception to get health care services for drugs not covered or for **brand-name**, **specialty** or **biosimilar prescription drugs** or for which health care services are denied through **precertification** or **step therapy.** You or your **prescriber** can contact us. You will need to provide us with the required clinical documentation. We will make a coverage determination within 72 hours after we receive your request and any information and will tell you and your **prescriber** of our decision. Any exception granted is based upon an individual, case by case decision, and will not apply to other members. If approved by us, you will receive the non-preferred benefit level and the exception will apply for the entire time of the **prescription**.

You, someone who represents you or your **prescriber** may seek a quicker medical exception process to get coverage for non-covered drugs in an urgent situation. An urgent situation happens when you have a health condition that may seriously affect your life, health, or ability to get back maximum function or when you are going through a current course of treatment using a **non-preferred drug**. You, someone who represents you or your **prescriber** may submit a request for a quicker review for an urgent situation by:

- Contacting our Precertification Department at 1-855-582-2025,
- Faxing the request to 1-855-330-1716.
- Submitting the request in writing to CVS Health ATTN: **Innovation Health**, 1300 E Campbell Road Richardson, TX 75081.

We will make a coverage determination within 24 hours after we receive your request and will tell you, someone who represents you and your **prescriber** of our decision. If approved by us, the exception will apply for the entire time you have an urgent situation.

If you are denied a medical exception based on the above processes, you may have the right to a third party review by an independent external review organization. If our claim 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 also will describe the external review process. We will tell you, someone who represents you or your **prescriber** of the coverage determination of the external review no later than 72 hours after we receive your request. If the medical exception is approved, coverage will be provided for the entire time of the prescription. For quicker medical exceptions in urgent situations, we will tell you, someone who represents you or your **prescriber** of the coverage determination no later than 24 hours after we receive your request. If the quicker medical exception is approved, coverage will be provided for the entire time you have an urgent situation.

Prescribing units

Some **prescription drugs** are subject to quantity limits. These quantity limits help your **prescriber** and pharmacist check that your **prescription drug** is used correctly and safely. We rely on medical guidelines, FDA-approved recommendations and other criteria developed by us to set these quantity limits.

Depending on the form and packing of the product, some **prescription drugs** are limited to 100 units (except insulin) dispensed per **prescription** order or refill. Drugs that are allowed to be filled with greater than 31 day supply at a **retail pharmacy** are limited to 300 units dispensed per **prescription** order or refill.

Any **prescription drug** that is made to work beyond one month shall require the number of **copayments** per **prescription** that is equal to the anticipated duration of the medication. For example, one injection of a drug that works for three months would require three **copayments**.

Specialty prescription drugs may have limited access or distribution and are limited to no more than a 30 day supply.

What your plan doesn't cover –exceptions and exclusions

We already told you about the many health care services and supplies that are eligible for coverage under your plan in the *Eligible health services under your plan* section. In that section we also told you that some health care services and supplies have exceptions and some are not covered at all (exclusions). For example, **physician** care is an **eligible health service** but **physician** care for **cosmetic** surgery is never covered. This is an exclusion.

In this section we tell you about the exceptions and exclusions that apply to your plan.

And just a reminder, you'll find benefit and coverage limitations in the schedule of benefits.

Exceptions and exclusions

The following are not **eligible health services** under your plan except as described in the *Eligible health services under your plan* section of this certificate or by an amendment included with this certificate:

Acupuncture, **acupressure and acupuncture therapy**, except where described in the ***Eligible health services under*** *your plan* section.

Ambulance services

- **Ambulance** services, for routine transportation to receive outpatient or inpatient services

Autism spectrum disorder

- Early intensive behavioral interventions (including Denver, LEAP, TEACCH, Rutgers, floor time, Lovaas and similar programs) and other intensive educational interventions

Artificial organs

- Any device that would perform the function of a body organ

Blood services, 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 services of blood donors, apheresis or plasmapheresis

For autologous blood donations, only administration and processing expenses are covered.

Clinical trial therapies (routine patient costs)

- Services and supplies related to data collection and record-keeping that is not used in the direct clinical management of the patient.

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 as covered under the ***Eligible health services*** *under your policy- Reconstructive surgery and supplies* section.

Counseling

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

Custodial care

Examples are:

- Routine patient care such as changing dressings, periodic turning and positioning in bed
- Administering oral medications
- Care of a 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/changing containers and clamping tubing)
- Watching or protecting you
- Respite care, adult (or child) day care, or convalescent care
- Institutional care. This includes **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
- Any service performed by a person without any medical or paramedical training

This exclusion does not apply to services covered in the ***Eligible health services*** *under your policy-Hospice care* section.

Dental care for adults

- Dental services related to:
  - The care, filling, removal or replacement of teeth and treatment of diseases of the teeth
  - Dental services related to the gums
  - Apicoectomy (dental root resection)
  - Orthodontics
  - Root canal treatment
  - Soft tissue impactions
  - Alveolectomy
  - Augmentation and vestibuloplasty treatment of periodontal disease
  - False teeth
  - Prosthetic restoration of dental implants
  - Dental implants

  This exclusion does not apply to services covered under the ***Eligible health services*** *under your policy- Adult dental care* section.

Durable medical equipment (DME)

Appliances, devices, and medical supplies that have both a non-therapeutic and therapeutic use. Examples of these items are:

- Whirlpools
- Portable whirlpool pumps
- Massage table

- Sauna baths
- Message devices (personal voice recorder)
- Over bed tables
- Elevators
- Communication aids
- Vision aids
- Telephone alert systems

Educational services

Examples of those services are:

- Any service or supply for education, training or retraining services or testing. This includes special education, remedial education, job training and job hardening programs
- Evaluation or treatment of learning disabilities, attention deficit disorder, developmental, learning and communication disorders, behavioral disorders or training, regardless of the main cause
- Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and delays in developing skills
- Services such as speech therapy eligible under the Individuals with Disabilities in Education Act (IDEA)

Emergency services and urgent care

- Non-emergency care in a **hospital** emergency room facility except for initial screening and stabilization services
- Non-urgent care in an **urgent care facility** or at a non-hospital freestanding facility

Examinations

Except as covered under the ***Eligible health services*** *under your policy – Preventive care and wellness* section health or dental examinations needed:

- Because a third party requires the exam. Examples include examinations to get or keep a job, or examinations required under a labor agreement or other contract.
- Because a court order requires it.
- To buy insurance or to get or keep a license.
- To travel.
- To go to a school, camp, or 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 trial therapies (**experimental or investigational**) or covered under clinical trials (routine patient costs).

Facility charges

For care, services or supplies provided in:

- Rest homes
- Assisted living facilities
- Similar institutions serving as a person's main residence or providing mainly custodial or rest care

- Health resorts
- Spas or sanitariums
- Infirmaries at schools, colleges, or camps

Family planning services – female contraceptives counseling, devices and voluntary sterilization

Examples of services and supplies that are not covered under the preventive care and wellness benefit include:

- Over-the-counter (OTC) contraceptive supplies, such as male and female condoms, spermicides and sponges
- OTC emergency contraceptives
- Any drug, or supply to prevent or terminate pregnancy, including birth control pills, patches and implantable **prescription drug** contraceptives
- Female contraceptives that are **brand-name prescription drugs** and **biosimilar prescription drugs**
- Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA
- FDA approved female brand-name and biosimilar emergency contraceptives
- Contraception services during a **stay** in a **hospital** or other facility for medical care
- Male contraceptive methods, sterilization procedures or devices
- The reversal of voluntary sterilization procedures, including any related follow-up care

Family planning services - other

- Reversal of voluntary sterilization procedures including related follow-up care
- Charges incurred for family planning services while confined as an inpatient in a **hospital** or other facility.

Foot care

- Services and supplies for:
  - The treatment of calluses, bunions except for capsular or bone surgery), toenails, hammertoes, fallen arches
  - The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes
  - Supplies (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies

  Unless specifically required for treatment or to prevent complications of diabetes or vascular disease.

Habilitation therapy services

Physical, occupational and speech therapy

- Except for physical therapy, occupational therapy or speech therapy provided for the treatment of autism spectrum disorder, therapies to treat delays in development and/or chronic conditions. Examples of non-covered diagnoses that are considered both developmental and/or chronic in nature are:
  - Autism spectrum disorders
  - Down syndrome

- Any service unless provided in accordance with a specific treatment plan
- Services you get from a **home health care agency**
- Services not given by a **physician** (or under the direct supervision of a **physician**), physical, occupational or speech therapist
- Services for the treatment of delays in development, including speech development, unless as a result of a birth defect.

Hearing aids and exams unless otherwise covered under the ***Eligible Health Services*** section

Home health 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
- Applied behavior analysis

Hospice care

- Funeral arrangements.
- Pastoral counseling.
- Financial or legal counseling. This includes estate planning and the drafting of a will.
- Services which are not related to your care and may include:
  - Sitter or companion services for either you or other family members except for respite care.
  - Transportation.
  - Maintenance of the house.

Jaw joint disorder

Except as covered in the ***Eligible health services*** *under your policy- Bones or joints of the head, neck, face or jaw treatment* section*:*

- Fixed or removable appliances that involve movement or repositioning of the teeth
  Repair of teeth (fillings)
- Prosthetics (crowns, bridges, dentures)

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. Except as covered in the ***Eligible health services*** *under your policy – Outpatient rehabilitation and habilitation, physical, occupational, and speech therapy* section.

Medical supplies – outpatient disposable over-the-counter items

- Sheaths
- Bags
- Elastic garments
- Support hose
- Bandages

- Bedpans
- Other home test kits
- Compresses

Mental health treatment

- Mental health services for the following categories (or equivalent terms as listed in the most recent version of the *International Classification of Diseases* (ICD)):
  - Dementias and amnesias without behavioral disturbances
  - Sexual deviations and disorders except for gender identity disorders
  - Tobacco use disorders
  - Specific disorders of sleep
  - Antisocial or dissocial personality disorder
  - Pathological gambling, kleptomania, pyromania
  - Specific delays in development (learning disorders, academic underachievement)
  - Intellectual disability
  - Wilderness treatment program or any such related or similar program
  - School and/or education service
- Transportation

Nutritional supplements

- Any food item, including infant formulas, nutritional supplements, vitamins, plus **prescription** vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition, except as covered in the *Eligible health services under your plan – Other services* section or in the ***Eligible health services*** *under your policy – Outpatient* ***prescription drugs*** section

Obesity (bariatric) surgery

- Weight management treatment or drug intended to decrease or increase body weight, control weight or treat obesity, including **morbid obesity** except as covered in the *Eligible health services under your plan – Other services* section and the *Preventive care and wellness - Preventive screening and counseling services* section 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, 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 primary payer

- Payment for a portion of the charge that Medicare or another party is responsible for as the primary payer. This exclusion does not apply to laws that make the government program the secondary payer after benefits under this policy have been paid.

Outpatient infusion therapy

- **Specialty prescription drugs** and medicines provided by your employer or through a third party vendor contract with your employer
- Drugs that are included on the list of **specialty prescription drugs** as covered under your outpatient **prescription drug** plan in the ***Eligible Health Services*** *under your policy –Outpatient prescription drug- Specialty care* ***prescription drug****s* section.

Outpatient prescription drugs

- Abortion drugs provided during a procedure to terminate pregnancy. For medical coverage see the ***Eligible health services*** *under your policy- Family planning* section. Allergy serum and extracts. For medical coverage see the ***Eligible health services*** *under your policy -Physicians and other health professionals* section.
- Any charges related to the injection or application of a drug except as covered at an authorized pharmacy or walk-in clinic.
- Biological liquids and fluids**-** For medical coverage see the ***Eligible health services*** *under your policy-Other Services- Blood products and blood infusion equipment* section.
- **Brand-name prescription drugs** and devices when a **generic prescription drug** equivalent, **biosimilar prescription drug** or **generic prescription drug** alternative is available, unless otherwise covered by medical exception
- **Cosmetic** drugs
    - **Cosmetic** drugs, medications or preparations used for **cosmetic** purposes
- Compound drugs unless you need a prescription for at least one ingredient and the drug is not essentially a copy of a commercially available drug product
- Dietary supplements
- Drugs or medications:
    - Which do not, by federal or state law, require a **prescription** order (i.e. over-the-counter (OTC) drugs), even if a **prescription** is written, except where stated in the *Eligible health services under your plan – Outpatient prescription drugs* section
    - That includes the same active ingredient or a modified version of an active ingredient
    - That is therapeutically equivalent or a therapeutic alternative to a covered **prescription drug** unless a medical exception is approved
    - That is therapeutically equivalent or a therapeutic alternative to an over-the-counter (OTC) product unless a medical exception is approved
    - Provided by, or while the person is an inpatient in, any healthcare facility, or for any drugs provided on an outpatient basis in any such institution to the extent benefits are payable for it
    - That include methadone maintenance medications used for drug **detoxification** except as covered under ***Eligible health services****- **Substance use disorder***

  - That includes vitamins and minerals except as covered in the *Eligible health services under your policy – Outpatient prescription drugs- Preventive care drugs and supplements* section.
  - For which the cost is recoverable under any federal, state, or government agency or any medication for which there is no charge made to the recipient
  - That are used for the treatment of 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.
  - 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
- Genetic care
  - Any treatment, device, drug, service or supply to alter the body's genes, genetic make-up, or the expression of the body's genes except for the correction of congenital birth defects
- Immunizations related to travel or work unless such services are received as part of the covered preventive care services
- Immunization or immunological agents. For medical coverage see the ***Eligible health services*** *under your policy-Preventive care and wellness* section
- Implantable drugs and associated devices except where stated in the *Eligible health services under your plan – Preventive care and wellness* and *Outpatient prescription drugs* sections
- **Infertility**
  - Injectable **prescription drugs** used primarily for the treatment of **infertility**.
- Injectables:
  - Any charges for the administration or injection of **prescription drugs** or injectable insulin and other injectable drugs covered by us.
  - Injectable drugs dispensed by out-of-network **pharmacies.**
  - Needles and syringes, including but not limited to diabetic needles and syringes, except where stated in the *Eligible health services under your plan – Diabetic equipment, supplies and education* section.
  - Injectable drugs, unless dispensed through the network **specialty pharmacy.**
  - For any refill of a designated **specialty prescription drug** not dispensed by or obtained through the network **specialty pharmacy**.
- An updated copy of the list of **specialty prescription drugs** designated by this plan to be refilled by or obtained through the network **specialty pharmacy** is available upon request or may be accessed by logging onto your secure member website at www.innovationhealth.com.
- Insulin pumps or tubing or other ancillary equipment and supplies for insulin pumps except as covered in the ***Eligible health services*** *under your policy – Diabetic equipment, supplies and education* section.
- **Prescription drugs**:
  - Dispensed by an out-of-network **mail order pharmacy**, except in a medical emergency or urgent care situation
  - Filled prior to the effective date or after the end date of coverage under this plan
  - That include an active metabolite, stereoisomer, prodrug (precursor) or altered formulation of another drug and is no clinically superior to that drug as determined by the plan

- That are considered oral dental preparations and fluoride rinses, except pediatric fluoride tablets or drops as specified on the **preferred drug guide**
- That are **non-preferred drugs**, unless **non-preferred drugs** are specifically covered as described in your schedule of benefits. However, a **non-preferred drug** will be covered if in the judgment of the **prescriber** there is no equivalent **prescription drug** on the **preferred drug guide** or the product on the **preferred drug guide** is ineffective in treating your disease or condition or has caused or is likely to cause an adverse reaction or harm you
- That are not covered or related to a non-covered service
- 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 would be illegal, unethical, imprudent, abusive, not **medically necessary**, or otherwise improper and drugs obtained for use by anyone other than the member identified on the ID card

We reserve the right to include only one manufacturer's product on the **preferred drug guide** when the same or similar drug (that is, a drug with the same active ingredient), supply or equipment is made by two or more different manufacturers.

We reserve the right to include only one dosage or form of a drug on the **preferred drug guide** when the same drug (that is, a drug with the same active ingredient) is available in different dosages or forms from the same or different manufacturers. The product in the dosage or form that is listed on our **preferred drug guide** will be covered at the applicable **copayment** or **coinsurance**.

- Prophylactic drugs for travel
- Refills
  - Refills dispensed more than one year from the date the latest **prescription** order was written, or as otherwise permitted by applicable law of the area in which the drug is dispensed
- Replacement of lost or stolen prescriptions
- Tobacco use
  - 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). See the *Eligible health services under the plan – Outpatient prescription drugs* section.
- Test agents except diabetic test agents

Outpatient surgery

- The services of any other **physician** who helps the operating **physician** when not **medically necessary** based on medical standards**.**
- A **stay** in a **hospital** (A **hospital stay** is an inpatient **hospital** benefit. See *the Eligible health services under your plan – Hospital and other facility care* section.)
- A separate facility charge for **surgery** performed in a **physician's** office.
- Services of another **physician** for the administration of a local anesthetic.

Pediatric dental care

In addition to the exclusions that apply to health coverage:

- Any instruction for diet, plaque control and oral hygiene
- **Cosmetic** services and supplies including:
  - Plastic surgery, reconstructive surgery, **cosmetic** surgery, personalization or characterization of dentures or other services and supplies which improve alter or enhance appearance
  - Augmentation and vestibuloplasty, and other substances to protect, clean, whiten bleach or alter the appearance of teeth, , except to the extent coverage is specifically provided in the *Eligible health services under your plan* section
  - Facings on molar crowns and pontics will always be considered cosmetic
- Crown, inlays, onlays, and veneers unless:
  - It is treatment for decay or traumatic **injury** and teeth cannot be restored with a filling material, or
  - The tooth is an abutment to a covered partial denture or fixed bridge
- Dental implants and braces (that are determined not to be **medically necessary**), mouth guards and other devices to protect, replace or reposition teeth
- Dentures, crowns, inlays, onlays, bridges, or other appliances or services used:
  - For splinting
  - To alter vertical dimension
  - To restore occlusion
  - For correcting attrition, abrasion, abfraction or erosion
- Treatment of any **jaw joint disorder** and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint disorder (TMJ) treatment, orthognathic **surgery**, and treatment of malocclusion or devices to alter bite or alignment, except as covered in the *Eligible health services under your plan – Specific conditions* section
- General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another **eligible health service**
- Orthodontic treatment except as covered in the *Eligible health services under your plan – Pediatric dental care* section
- Pontics, crowns, cast or processed restorations made with high noble metals (gold)
- Prescribed drugs, pre-medication
- Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures
- Replacement of teeth beyond the normal complement of 32
- Routine dental exams and other preventive services and supplies, except as specifically described in the *Eligible health services under your plan – Pediatric dental care* section
- Services and supplies:
  - Done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services
  - Provided for your personal comfort or convenience or the convenience of another person, including a provider
  - Provided in connection with treatment or care that is not covered under your policy

- Surgical removal of impacted wisdom teeth that is not **medically necessary** and only for orthodontic reasons
- Treatment by other than a **dental provider**

Personal care, comfort or convenience items

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

Private duty nursing in an in-patient setting

Prosthetic devices

- Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes, or if 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

Rehabilitation services

Outpatient rehabilitation, physical, occupational and speech therapy

- Therapies to treat delays in development.
- Any service unless provided in accordance with a specific treatment plan
- Services you get from a **home health care agency**
- Services provided by a **physician**, or treatment covered as part of the spinal manipulation benefit.
  - This applies whether or not benefits are paid under the spinal manipulation section
- Services not given by a **physician** (or under the direct supervision of a **physician**), physical, occupational or speech therapist
- Services for the treatment of delays in development, including speech development, unless as a result of a birth defect.

Services provided by a family member

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

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**, service, 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 or appearance of a sex organ
  - Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services

Specialty prescription drugs

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

Strength and performance

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

Telemedicine

Any services that are audio-only telephone, electronic mail message or facsimile transmission.

Therapies and tests

- Full body CT scans that are not **medically necessary**
- Hair analysis
- Hypnosis and hypnotherapy
- Massage therapy, except when used as a physical therapy modality
- Sensory or auditory integration therapy

Tobacco cessation

Except where described in the ***Eligible Health Services*** *under your policy* section:

- 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 where stated in the *Eligible health services under your plan – Preventive care and wellness* section
  - Hypnosis and other therapies
  - Medications, except where stated in the *Eligible health services under your plan – Outpatient prescription drugs* section
  - Nicotine patches
  - Gum

Transplant 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, or hematopoietic stem cells without intending to use them for transplantation within 12 months from harvesting, for an existing **illness**

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, except to the extent coverage is required by applicable laws

Treatment of infertility

All charges associated with the treatment of infertility, except as described under the *Eligible health services under your policy – Treatment of infertility – Basic infertility* section. This includes:

- All charges associated with:
  - Surrogacy when the surrogate is not a covered person under your plan. A surrogate is a female carrying her own genetically related child where the child is conceived with the intention of turning the child over to be raised by others, including the biological father.
  - Cryopreservation of eggs, embryos, or sperm.
  - Storage of eggs, embryos, or sperm.
  - Thawing of cryopreserved eggs, embryos or sperm.
  - The care of the donor in a donor egg cycle. This includes, but is not limited to, any payments to the donor, donor screening fees, fees for lab tests, and any charges associated with care of the donor required for donor egg retrievals or transfers.
  - The use of a gestational carrier for the female acting as the gestational carrier. A gestational carrier is a female carrying an embryo to which she is not genetically related.
- Home ovulation prediction kits or home pregnancy tests.
- Injectable **infertility** medication, including but not limited to menotropins, hCG, and GnRH agonists.
- The purchase of donor embryos, donor oocytes, or donor sperm.
- Reversal of voluntary sterilizations, including follow-up care.
- Any charges associated with obtaining sperm for ART services.
- Ovulation induction with menotropins, intrauterine insemination and any related services, products or procedures.
- In vitro fertilization (IVF), Zygote intrafallopian transfer (ZIFT), Gamete intrafallopian transfer (GIFT), Cryopreserved embryo transfers and any related services, products or procedures (such as Intracytoplasmic sperm injection (ICSI) or ovum microsurgery).

Vision care

Pediatric vision care

Except as specifically covered in the ***Eligible health services*** *under your policy- Vision Care*

- Eyeglass frames, **prescription** lenses and **prescription** contact lenses that are not identified as preferred by a vision **provider**
- Eyeglass frames, non-**prescription** lenses and non-**prescription** contact lenses that are for **cosmetic** purposes

Adult vision care

Services and supplies

Your plan does not cover vision care services and supplies, except as described in the *Eligible health services under your plan – Other services* section.

- Special supplies such as non-**prescription** sunglasses
- Eyeglass frames, non-**prescription** lenses and non-**prescription** contact lenses that are for **cosmetic** purposes
- Special vision procedures, such as orthoptics or vision therapy
- Eye exams during your **stay** in a **hospital** or other facility for health care
- Eye exams for contact lenses or their fitting

- Eyeglasses or duplicate or spare eyeglasses or lenses or frames
- Replacement of lenses or frames that are lost or stolen or broken
- Acuity tests
- Eye **surgery** for the correction of vision, including radial keratotomy, LASIK and similar procedures
- Services to treat errors of refraction

Wilderness treatment programs

- Wilderness treatment programs (whether or not the program is part of a **residential treatment facility** or otherwise licensed institution)
- Educational services, schooling or any such related or similar program, including therapeutic programs within a school setting

Work related illness or injuries

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

Who provides the care

Just as the starting point for coverage under your plan is whether the services and supplies are **eligible health services**, the foundation for getting covered care is the network. This section tells you about **network** and **out-of-network providers**.

Network providers

We have contracted with **providers** to provide **eligible health services** to you. These **providers** make up the network for your plan. For you to receive the network level of benefits you must use **network providers** for **eligible health services**. There are some exceptions:

- **Emergency services** – refer to the description of **emergency services** and urgent care in the *Eligible health services under your plan* section.
- Urgent care – refer to the description of **emergency services** and urgent cares in the *Eligible health services under your plan* section.

You may select a **network provider** from the **directory** or by logging on to our website at www.innovationhealth.com. You can search our online **directory** for names and locations of **providers**.

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

Your PCP

We encourage you to access **eligible health services** through a **PCP**. They will provide you with primary care.

A **PCP** can be any of the following **providers** available under your plan:

- General practitioner
- Family physician
- Internist
- Pediatrician
- OB, GYN, and OB/GYN

How do you choose your PCP?

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

Each covered family member is encouraged to select a **PCP.** You may each select 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 will your PCP do for you?

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

Your **PCP** can also:

- Order lab tests and radiological services
- Prescribe medicine or therapy
- Arrange a **hospital stay** or a **stay** in another facility

How do I change my PCP?

You may change your **PCP** at any time. You can call us at the toll-free number on your ID card or log on to your secure member website at www.innovationhealth.com to make a change.

Out-of-network providers

You also have access to **out-of-network providers.** This means you can receive **eligible health services** from an **out-of-network provider**. If you use an **out-of-network provider** to receive **eligible health services**, you are subject to a higher out-of-pocket expense and are responsible for:

- Paying your out-of-network **deductible**
- Your out-of-network **coinsurance**
- Any charges over our **recognized charge**
- Submitting your own claims and getting **precertification** when required

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 a member and your **provider** stops being in our network

However, in some cases, you may be able to keep going to your current **provider** to complete a treatment or to have treatment that was already scheduled. This is called continuity of care.

	If you are a new enrollee and your provider is not contracted with us	**When your provider stops participation with us**
Request for approval	You need to complete a Transition of Coverage Request form and send it to us. Call Member Services at the number on the back of your ID card to get the form.	You or your **provider** should call us for approval to continue any care.
Length of transitional period	Care will continue during a transitional period, usually 90 days, but this may vary based on your condition.	Care will continue during a transitional, period usually 90 days, but this may vary based on your condition.

	If you are a new enrollee and your provider is not contracted with us
Request for approval	You need to complete a Transition of Coverage Request form and send it to us. Call Member Services at the number on the back of your ID card to get the form.
Length of transitional period	Care will continue during a transitional period, usually 90 days, but this may vary based on your condition.
How claim is paid	Your claim will be paid at the network **provider** cost sharing level.

If you are pregnant and in your second trimester, the transitional period 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.

We will authorize coverage for the transitional period only if the **provider** agrees to our usual terms and conditions for contracting **providers**. The continuity of care provision does not apply if the **provider** has been terminated for cause.

What the plan pays and what you pay

Who pays for your **eligible health services** – this plan, both of us, or just you? That depends. This section gives the general rule and explains these key terms:

- Your **deductible**
- Your **copayments/coinsurance**
- Your **maximum out-of-pocket limit**

We also remind you that sometimes you will be responsible for paying the entire bill – for example, if you get care that is not an **eligible health service**.

The general rule

When you get **eligible health services**:

- You pay for the entire expense up to any **deductible** limit.

And then

- The plan and you share the expense up to any **maximum out-of-pocket limit**. The schedule of benefits lists how much your plan pays and how much you pay for each type of health care service. Your share is called a **copayment/coinsurance**.

And 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 **negotiated charge** for a **network provider**, and **recognized charge** for an **out-of-network provider**. See the *Glossary* section for what these terms mean.

Important note – when your plan pays all

Your plan pays the entire expense for all in-network **eligible health services** under the preventive care and wellness benefit.

Important note– when you pay all

You pay the entire expense for an **eligible health service**:

- When you get a health care service or supply that is not **medically necessary**. See the *Medical necessity and precertification requirements* section.
- When your plan requires **precertification**, it was requested, we refused it, and you get an **eligible health service** without **precertification**. See the *Medical necessity and precertification requirements* section.

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

Special financial responsibility

You are responsible for the entire expense of:

- Cancelled or missed appointments

Neither you nor we are responsible for:

- Charges for which you have no legal obligation to pay
- Charges that would not be made if you did not have coverage
- Charges, expenses or costs in excess of the **negotiated charge** for in-network **covered benefits**.

Where your schedule of benefits fits in

How your medical plan deductible works

The **deductible** is the amount you need to pay for **eligible health services** before your plan begins to pay for **eligible health services**. Your schedule of benefits shows the **deductible** amounts for your plan.

Your schedule of benefits shows the **deductible** amounts that apply to your plan. Once you have met your **deductible**, we will start sharing the cost when you get **eligible health services**. You will continue to pay **copayments/coinsurance** for **covered benefits** after you meet any applicable **deductible**.

How your copayment/coinsurance works

Your **copayment/coinsurance** is the amount you pay for **eligible health services** after you have paid your **deductible**. Your schedule of benefits shows you what **copayments/coinsurance** you will pay for specific **eligible health services**. We can change your **copayments** if we give the **policyholder** 30 days written notice.

You will pay the **PCP copayment/coinsurance** when you receive **eligible health services** from any **PCP**.

How your maximum out-of-pocket limit works

You will pay your **deductible** and **copayments/coinsurance** up to the **maximum out-of-pocket limit** for your plan. Your schedule of benefits shows the **maximum out-of-pocket limits** that apply to your plan. After you reach the your **maximum out-of-pocket**, you will be notified by us no later than 30 days after we have processed sufficient claims to determine you have met the **maximum out-of-pocket**. You will not be required to pay cost share for **eligible health services** for the rest of the **plan year**. Any amounts over your **maximum out-of-pocket** will be promptly refunded to you.

Important note:
See the schedule of benefits for any **deductibles, copayments/coinsurance, maximum out-of-pocket limit** and maximum age, visits, days, hours, admissions and other limitations that may apply.

When you disagree - claim decisions and appeal procedures

In the previous section, we explained how you and we share responsibility for paying for your **eligible health services**.

When a claim comes in, we review it, make a decision and tell you how you and we will split the expense. We also explain what you can do if you think we got it wrong.

Claim procedures

For claims involving **out-of-network providers**:

Notice	Requirement	Deadline
Submit a claim	• You should notify and request a claim form from us. • The claim form will provide instructions on how to complete and where to send the form(s).	• You must send us notice and proof as soon as reasonably possible. • If you are unable to complete a claim form, you may send us: ▪ A description of services ▪ Bill of charges ▪ Any medical documentation you received from your provider
Proof of loss (claim) When you have received a service from an eligible provider, you will be charged. The information you receive for that service is your proof of loss.	• A completed claim form and any additional information required by us.	• You must send us notice and proof as soon as reasonably possible.
Benefit payment	• Written proof must be provided for all benefits. • If any portion of a claim is contested by us, the uncontested portion of the claim will be paid promptly after the receipt of proof of loss.	• Benefits will be paid as soon as the necessary proof to support the claim is received.

Types of claims and communicating our claim decisions

You or your **provider** are required to send us a claim in writing. You can request a claim form from us. We will review that claim for payment to the **provider** or to you as appropriate.

There are different types of claims. The amount of time that we have to tell you about our decision on a claim depends on the type of claim. The section below will tell you about the different types of claims.

Urgent care claim

An urgent claim is one for which 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. Or it could be a situation in which you need care to avoid severe 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.

Post-service claim

A post service claim is a claim that involves health care services you have already received.

Concurrent care claim extension

A concurrent care claim extension happens when you ask 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**.

Concurrent care claim reduction or termination

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

During this continuation period, you are still responsible for your share of the costs, such as **copayments/coinsurance** and **deductibles** that apply to the service or supply. If we support 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.

The chart below shows the different types of claims and how much time we have to tell you about our decision.

We may need to tell your **physician** about our decision on some types of claims, such as a concurrent care claim, or a claim when you are already receiving the health care services or are in the **hospital**.

Type of notice	Urgent care claim	Pre-service claim	Post-service claim	Concurrent care claim
Initial decision by us	72 hours (24 hours for appeals that relate to a **prescription** to alleviate cancer pain)	15 days	30 days	24 hours for urgent request*, or 72 hours if clinical information is required and received more than 24 hours after request *
Extensions	Not applicable	15 days	15 days	
If we request more information	24 hours	15 days	15 days	
Time you have to send us additional information	48 hours	45 days	45 days	

***We have to receive the request at least 24 hours before the previously approved health care services end.

Adverse benefit determinations

We pay many claims at the full rate **negotiated charge** with a **network provider** and the **recognized charge** with an **out-of-network provider**, except for your share of the costs. But sometimes we pay only some of the claim. And sometimes we don't pay at all. Any time we don't pay even part of the claim that is an "adverse benefit determination" or "adverse decision". It is also an "adverse benefit determination" if we 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.

If we make an adverse benefit determination, we will tell you in writing.

The difference between a complaint and an appeal

A complaint

You may not be happy about a **provider** or an operational issue, and you may want to complain. You can call or write Member Services. Your complaint should include a description of the issue. You should include copies of any records or documents that you think are important. We will review the information and provide you with 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.

An appeal

You can ask us to re-review an adverse benefit determination. This is called an appeal. You can appeal to us verbally or in writing.

Appeals of adverse benefit determinations

You can appeal our adverse benefit determination. We will assign your appeal to someone who was not involved in making the original decision. 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 you can call Member Services at the number on your ID card. You need to include:

- The member's name
- Your employer's name
- A copy of the adverse benefit determination
- Your reasons for making the appeal
- Any other information you would like us to consider

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 that you are allowing someone to appeal for you. You can get this form by contacting us. You can use an authorized representative at any level of appeal.

You can appeal two times under this plan. If you appeal a second time you must present your appeal within 60 calendar days from the date you receive the notice of the first appeal decision.

Urgent care or pre-service claim appeals

If your claim is an urgent claim or a pre-service claim, your **provider** may appeal for you without having to fill out a form.

We will provide you with any new or additional information that we used or that was developed by us to review your claim. We will provide this information at no cost to you before we give you a decision at your last available level of appeal. This decision is called the final adverse benefit determination. You can respond to this information before we tell you what our final decision is.

Timeframes for deciding an appeal

The amount of time that we have to tell you about our decision on an appeal claim depends on the type of claim. The chart below shows a timetable view of the different types of claims and how much time we have to tell you about our decision.

Type of notice	Urgent care claim	Pre-service claim	Post-service claim	Concurrent care claim
Appeal determinations at each level (us)	72 hours (24 hours for appeals that relate to a **prescription** to alleviate cancer pain)	30 days	60 days	As appropriate to type of claim
Extensions	None	None	None	

Exception request for prescription drugs

See the Medical necessity and precertification requirements- how can I request a medical exception? section for information on requesting and gaining access to clinically appropriate **prescription drugs** that are not covered under this policy.

Exhaustion of appeals process

You are encouraged to complete the appeals process with us before you contact the Virginia Bureau of Insurance to request an investigation of a complaint or appeal.

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

- Contact the Virginia Bureau of Insurance. to request an investigation of a complaint or appeal.
- File a complaint or appeal with the Virginia Bureau of Insurance.
- 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 appeals process before you may take other actions. These are when:

- You have an urgent claim or a claim that involves ongoing treatment. You can have your claim reviewed internally and at the same time through the external review process.
- We did not follow all of the claim determination and appeal requirements of the State or Federal Department of Health and Human Services. 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.

External review

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

You have a right to external review only if:

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

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
- And you must include a copy of the notice from us and all 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 the 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, unless we can show conflict of interest, bias or fraud.

How long will it take to get an IRO decision?

We will tell you of 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 call us or send us a Request for External Review Form. There are two scenarios when you may be able to get a faster external review:

For initial adverse determination

Your **provider** tells us that a delay in your receiving health care services would:

- Jeopardize your life, health or ability to regain maximum function
- Be much less effective if not started right away (usually for **experimental or investigational** treatment)

For final adverse determination

Your **provider** tells us that a delay in your receiving health care services would:

- Jeopardize your life, health or ability to regain maximum function
- Be much less effective if not started right away (**experimental or investigational** treatment)
- 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 us getting your 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
E-Mail: ombudsman@scc.virginia.gov

Virginia Department of Health, Office of Licensure and Certification

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

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

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

Recordkeeping

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

Fees and expenses

We do not pay any fees or expenses incurred by you when you submit a complaint or appeal.

Coordination of benefits

Some people have health coverage under more than one health plan. If you do, we will work together with your other plan(s) 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 terms will help you understand this section.

Allowable expense means:

- A health care expense that any of your health plans cover to any degree. If the health care service is not covered by any of the plans, it is not an allowable expense. For example, **cosmetic** surgery generally is not an allowable expense under this plan.

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

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

Here's how COB works

- The primary plan pays first. When this is the primary plan, we will pay your claims first as if the other plan does not exist.
- The secondary plan pays after the primary plan. When this is the secondary plan, we will pay benefits after the primary plan and will coordinate the payment based on any amount the primary plan paid.

We will never pay an amount that, when combined with payments from your other coverage, add up to more than 100% of the allowable expenses.

Determining who pays

Reading from top to bottom the first rule that applies will determine which plan is primary and which is secondary. A plan that does not contain a COB provision is always the primary plan.

If you are:	Primary plan	Secondary plan
Covered under the plan as an employee, retired employee or dependent	The plan covering you as an employee or retired employee.	The plan covering you as a dependent.
Eligible for Medicare	If you or a dependent have Medicare coverage, the rule above may be reversed. See the *How to contact us for help* section if you have questions.	

COB rules for dependent children		
Child of: • Parents who are married or living together	The "birthday rule" applies. The plan of the parent whose birthday[+] (month and day only) falls earlier in the **calendar year**. [+]Same birthdays--the plan that has covered a parent longer is primary	The plan of the parent born later in the year (month and day only)[+]. [+]Same birthdays--the plan that has covered a parent longer is primary
Child of: • Parents separated or divorced or not living together • With court-order	The plan of the parent whom the court said is responsible for health coverage. But if that parent has no coverage then the other spouse's plan.	The plan of the other parent. But if that parent has no coverage, then his/her spouse's plan is primary.
Child of: • Parents separated or divorced or not living together – court-order states both parents are responsible for coverage or have joint custody	Primary and secondary coverage is based on the birthday rule.	
Child of: • Parents separated or divorced or not living together and there is no court-order	The order of benefit payments is: • The plan of the custodial parent pays first • The plan of the spouse of the custodial parent (if any) pays second • The plan of the noncustodial parent pays next • The plan of the spouse of the noncustodial parent (if any) pays last	
Active or inactive employee	The plan covering you as an active employee (or as a dependent of an active employee) is primary to a plan covering you as a laid off or retired employee (or as a dependent of a former employee).	A plan that covers the person as a laid off or retired employee (or as a dependent of a former employee) is secondary to a plan that covers the person as an active employee (or as a dependent of an active employee).
COBRA or state continuation	The plan covering you as an employee or retiree, or the dependent of an employee or retiree, is primary to COBRA or state continuation coverage.	COBRA or state continuation coverage is secondary to the plan that covers the person as an employee or retiree, or the dependent of an employee or retiree.

Longer or shorter length of coverage	If none of the above rules determine the order of payment, the plan that has covered the person longer is primary.
Other rules do not apply	If none of the above rules apply, the plans share expenses equally.

How are benefits paid?

Primary plan	The primary plan pays your claims as if there is no other health plan involved.
Secondary plan	The secondary plan calculates payment as if the primary plan did not exist and then applies that amount to any allowable expenses under the secondary plan that were not covered by the primary plan. The secondary plan will coordinate payments so the total payments do not exceed 100% of the total allowable expense.
Benefit reserve each family member has a separate benefit reserve for each **calendar year**	The benefit reserve: • Is made up of the amount that the secondary plan saved due to COB • Is used to cover any unpaid allowable expenses • Balance is erased at the end of each year

How COB works with Medicare

This section explains how the benefits under this plan work with benefits available under Medicare.

When we say Medicare, we mean the health insurance provided by Title XVIII of the Social Security Act, as amended. It also includes Health Maintenance Organization (HMO) or similar coverage that is an authorized alternative to Parts A and B of Medicare.

You are eligible for Medicare when you meet the criteria for coverage because of:

- Your age
- A disability
- End stage renal disease (ESRD)

You are also eligible for Medicare even if you are not enrolled because you:

- Refused it
- Dropped it
- Did not make a proper request for it

When you are eligible for Medicare, the plan coordinates the benefits it pays with the benefits that Medicare pays. In the case of someone who is eligible due to age but not covered, the plan may pay as if you are covered by Medicare and coordinate benefits with the benefits Medicare would have paid had you enrolled in Medicare.

Sometimes, this plan is the primary plan, which means that the plan pays benefits before Medicare pays benefits. Sometimes, this plan is the secondary plan, and pays benefits after Medicare or after an amount that Medicare would have paid if you were covered.

Who pays first?

If you are eligible due to age and have group health plan coverage based on your or your spouse's current employment and:	**Primary plan**	**Secondary plan**
The employer has 20 or more employees	Your plan	Medicare
You are retired	Medicare	Your plan
If you have Medicare because of:		
End stage renal disease (ESRD)	Your plan will pay first for the first 30 months. Medicare will pay first after this 30 month period.	Medicare Your plan
A disability other than ESRD and your employer has more than 100 employees	Your plan	Medicare
Note regarding ESRD: If you were already eligible for Medicare due to age and then became eligible due to ESRD, Medicare will remain your primary plan and this plan will be secondary.		

This plan is secondary to Medicare in all other circumstances.

How are benefits paid?

We are primary	We pay your claims as if there is no Medicare coverage.
Medicare is Primary	We calculate our benefit as if there were no Medicare coverage and coordinate our benefit so that when combined with the Medicare payment, the total payment is no more than 100% of the allowable expense.

Charges that satisfy your Part B deductible will be applied in the order received. We will apply the largest charge first when two or more charges are received at the same time.

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. See the *How to contact us for help* section for details.

Right to receive and release needed information

We have the right to release or obtain any information we need for COB purposes. That includes information we need to recover any payments from your other health plans.

Right to pay another carrier

Sometimes another plan pays something we would have paid under your plan. When that happens, we will pay your plan benefit to the other plan.

Right of recovery

If we pay more than we should have under the COB rules, we may recover the excess from:

- Any person we paid or for whom we paid
- Any other plan that is responsible under these COB rules

When coverage ends

Coverage can end for a number of reasons. This section tells you how and why coverage ends. And when you may still be able to continue coverage.

When will your coverage end?

Your coverage under this plan will end if:

- The group policy ends
- This plan is discontinued
- You voluntarily stop your coverage
- You are no longer eligible for coverage
- Your employment ends
- You do not make the required contributions
- We end your coverage
- You become covered under another medical plan offered by your employer

When will coverage end for any dependents?

Coverage for your dependent will end if:

- Your dependent is no longer eligible for coverage.
- You do not make the required contribution toward the cost of dependent coverage.
- Your coverage ends for any of the reasons listed above.
- You enroll under a group Medicare plan that we offer and your coverage ends under that plan.

In addition, coverage for your domestic partner will end on the earlier of:

- The date this plan no longer allows coverage for domestic partners.
- The date the domestic partnership ends. You should provide your employer a completed and signed 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 plan coverage ends* section for more information.

Why would we end coverage?

We will give you 30 days advance written notice if we end your coverage because:

- You do not comply with plan provisions by cooperating or giving facts that we need to administer the COB provisions

- You commit fraud or intentionally misrepresent 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. Any statement made is considered a representation and not a warranty. We will only use a statement during a dispute if it is shared with you and your beneficiary, or the person making the claim.

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

When coverage may continue under the plan

Your coverage under this plan will continue if:

Your employment ends because of **illness, injury**, sabbatical or other authorized leave as agreed to by the **policyholder** and us.	If **premium** payments are made for you, you may be able to continue to coverage under the plan as long as the **policyholder** and we agree to do so and as described below: • Your coverage may continue, until stopped by the **policyholder**, but not beyond 30 months from the start of your absence.
Your employment ends because of a temporary lay-off, temporary leave of absence, sabbatical, or other authorized leave as agreed to by the **policyholder** and us.	If **premium** payments are made for you, you may be able to continue to coverage under the plan as long as the **policyholder** and we agree to do so and as described below: • Your coverage will not continue after the month in which your absence started.
Your employment ends because: • Your job has been eliminated • You have been placed on severance, or • This plan allows former employees to continue their coverage.	You may be able to continue coverage. See the *Special coverage options after your plan coverage ends* section.
Your employment ends because of a paid or unpaid medical leave of absence	If **premium** payments are made for you, you may be able to continue to coverage under the plan as long as the **policyholder** and we agree to do so and as described below: • Your coverage may continue until stopped by the **policyholder** but not beyond 30months from the start of the absence.
Your employment ends because of a leave of absence that is not a medical leave of absence	If **premium** payments are made for you, you may be able to continue to coverage under the plan as long as the **policyholder** and we agree to do so and as described below: • Your coverage will not continue after the month in which your absence started.
Your employment ends because of a military leave of absence.	If **premium** payments are made for you, you may be able to continue to coverage under the plan as long as the **policyholder** and we agree to do so and as described below: • Your coverage may continue until stopped by the **policyholder** but not beyond 18 months from the start of the absence.

It is your **policyholder's** responsibility to let us know when your employment ends. The limits above may be extended only if we and the **policyholder** agree in writing to extend them.

Special coverage options after your plan coverage ends

This section explains options you may have after your coverage ends under this plan. Your individual situation will determine what options you will have.

Consolidated Omnibus Budget Reconciliation Act (COBRA) Rights

What are your COBRA rights?

COBRA gives some people the right to keep their health coverage for 18, 29 or 36 months after a "qualifying event". COBRA usually applies to employers of group sizes of 20 or more.

Here are the qualifying events that trigger COBRA continuation, who is eligible for continuation and how long coverage can be continued.

Qualifying event causing loss of coverage	Covered persons eligible for continued coverage	Length of continued coverage (starts from the day you lose current coverage)
Your active employment ends for reasons other than gross misconduct	You and your dependents	18 months
Your working hours are reduced	You and your dependents	18 months
You divorce or legally separate and are no longer responsible for dependent coverage	Your dependents	36 months
You become entitled to benefits under Medicare	Your dependents	36 months
Your covered dependent children no longer qualify as dependent under the plan	Your dependent children	36 months
You die	Your dependents	36 months
You are a retiree eligible for retiree health coverage and your former employer files for bankruptcy	You and your dependents	18 months

When do I receive COBRA information?
The chart below lists who is responsible for giving the notice, the type of notice they are required to give and when.

Employer/Group health plan notification requirements		
Notice	**Requirement**	**Deadline**
General notice – employer or us	Notify you and your dependents of COBRA rights	Within 90 days after active employee coverage begins
Notice of qualifying event – employer	• Your active employment ends for reasons other than gross misconduct • Your working hours are reduced • You become entitled to benefits under Medicare • You die • You are a retiree eligible for retiree health coverage and your former employer files for bankruptcy	Within 30 days of the qualifying event or the loss of coverage, whichever occurs later
Election notice – employer or us	Notify you and your dependents of COBRA rights when there is a qualifying event	Within 14 days after notice of the qualifying event
Notice of unavailability of COBRA – employer or us	Notify you and your dependents if you are not entitled to COBRA coverage	Within 14 days after notice of the qualifying event
Termination notice – employer or us	Notify you and your dependents when COBRA coverage ends before the end of the maximum coverage period	As soon as practical following the decision that continuation coverage will end

You/your dependents notification requirements		
Notice of qualifying event – qualified beneficiary	Notify your employer if: • You divorce or legally separate and are no longer responsible for dependent coverage • Your covered dependent children no longer qualify as a dependent under the plan	Within 60 days of the qualifying event or the loss of coverage, whichever occurs later
Disability notice	Notify your employer if: • The Social Security Administration determines that you or a covered dependent qualify for disability status	Within 60 days of the decision of disability by the Social Security Administration, and before the 18 month coverage period ends
Notice of qualified beneficiary's status change to non-disabled	Notify your employer if: • The Social Security Administration decides that the beneficiary is no longer disabled	Within 30 days of the Social Security Administration's decision
Enrollment in COBRA	Notify your employer if: • You are electing COBRA	60 days from the qualifying event. You will lose your right to elect, if you do not: • Respond within the 60 days • And send back your application

How can you extend the length of your COBRA coverage?

The chart below shows qualifying events after the start of COBRA (second qualifying events):

Qualifying event	Person affected (qualifying beneficiary)	Total length of continued coverage
Disabled within the first 60 days of COBRA coverage (as determined by the Social Security Administration)	You and your dependents	29 months (18 months plus an additional 11 months)
• You die • 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 dependent under the plan	You and your dependents	Up to 36 months

How do you enroll in COBRA?

You enroll by sending in an application and paying the **premium**. Your employer has 30 days to send you a COBRA election notice. It will tell you how to enroll and how much it will cost. You can take 60 days from the qualifying event to decide if you want to enroll. You need to send your application and pay the **premium**. If this is completed on time, you have enrolled in COBRA.

When is your first premium payment due?

Your first **premium** payment must be made within 45 days after the date of the COBRA election.

How much will COBRA coverage cost?

For most COBRA qualifying events you and your dependents will pay 102% of the total plan costs. This additional 2% covers administrative fees. If you apply for COBRA because of a disability, the total due will be 150% of the plan costs.

Can you add a dependent to your COBRA coverage?

You may add a new dependent during a period of COBRA coverage. They can be added for the rest of the COBRA coverage period if:

- They meet the definition of an eligible dependent
- You notified your employer within 31 days of their eligibility
- You pay the additional required **premiums**

When does COBRA coverage end?

COBRA coverage ends if:

- Coverage has continued for the maximum period.
- The plan ends. If the plan is replaced, you may be continued under the new plan
- You and your dependents fail to make the necessary payments on time
- You or a covered dependent become entitled to benefits under Medicare
- You or your dependents are continuing coverage during the 19th to 29th months of a disability, and the disability ends

Continuation of coverage for other reasons

To request an extension of coverage**,** just call the toll-free Member Services number on your ID card.

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

Your coverage may be extended if you or a dependent 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 own occupation or any other occupation for pay or profit.

A 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 the dependent are no longer totally disabled
- When you become covered by another health benefits plan
- 12-36 months of coverage depending upon whether you were previously covered as an employee or as a dependent

How can you extend coverage when getting inpatient care when coverage ends?

Your coverage may be extended if you or your dependents 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
- 12-36 months of coverage depending upon whether you were previously covered as an employee or as a dependent

What exceptions are there for dental work completed after your coverage ends?

Your dental coverage may end while you or your covered dependent are in the middle of treatment. The plan does not cover dental services that are given after your coverage terminates. There is an exception.

The plan will cover the following services if they are ordered while you were covered by the plan, and installed within 30 days after your coverage ends:

- Inlays
- Onlays
- Crowns
- Removable bridges
- Cast or processed restorations
- Dentures
- Fixed partial dentures (bridges)
- Root canals

Ordered means:

- For a denture: the impressions from which the denture will be made were taken
- For a root canal: the pulp chamber was opened
- For any other item: the teeth which will serve as retainers or supports, or the teeth which are being restored:
  - Must have been fully prepared to receive the item
  - Impressions have been taken from which the item will be prepared

How can you extend coverage for vision care services and supplies when coverage ends?

If your coverage ends while you are not totally disabled**,** your plan will cover vision services and supplies for eyeglasses and contact lenses within 30 days after your coverage ends if:

- A complete vision exam was performed in the 30 days before your coverage ended, and the exam included refraction
- The exam resulted in contact or frame lenses being prescribed for the first time, or new contact or frame lenses ordered due to a change in **prescription**

How can you extend coverage for your disabled child beyond the plan age limits?

You have the right to extend coverage for your dependent child beyond the plan age limits. If your disabled child:

- Is not able to be self-supporting because of mental or physical disability
- Depends mainly on you for support

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

We may ask you to send us proof of the disability within 90 days of the date coverage would have ended. Before we extend coverage, we may ask that your child get a physical exam. We will pay for that exam.

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

How can I extend coverage for a dependent after I die?

Your dependents can continue coverage after your death if:

- You were covered at the time of your death
- The request is made within 60 days after your death
- Payment is made for the coverage

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

- The end of the 36th month period after your death
- They no longer meet the definition of dependent
- Dependent coverage stops under the plan
- The dependent becomes covered by another health benefits plan
- Any required contributions stop
- The date your spouse remarries

General provisions – other things you should know

Administrative provisions

How you and we will interpret this booklet-certificate

We prepared this booklet-certificate according to ERISA, and according to other federal and state laws that apply. You and we will interpret it according to these laws. Also, you are bound by our interpretation of this booklet-certificate when we administer your coverage, so long as we use reasonable discretion.

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**. They 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 too. Under certain circumstances, we or your employer or the law may change your plan. Only we may waive a requirement of your plan. No other person – including your employer or **provider** – can do this.

If a service cannot be provided to you

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

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

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 **eligible health 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 http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

Legal action

No legal action may be brought to recover on this policy within 60 days after written proof of loss has been given as required by this policy.

No legal action may be brought after 3 years from the time written proof of loss is required to be given.

Physical examinations and evaluations
At our expense, we have the right to have a **physician** of our choice examine you. This may be done as often as reasonably necessary while a claim pending.

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 the notification of a claim, proof of loss will be met by giving us a written statement of nature and extent of the loss within the time limit state in the Proof of Loss section.

Notice of Claim
Written notice of claim must be given to us within 20 days after a covered medical expense is incurred, or as soon as reasonably possible. Notice given by or for the policyholder to us at the address listed in this policy, or to our authorized agent identifying the policyholder, will be considered notice.

Proof of Loss
If the Policy provides for periodic payment for a continuing loss, written proof of loss must be given to us within 90 days after the end of each period for which we are liable. For any other loss, written proof must be given within 90 days after such loss. If it was not reasonably possible to give written proof in the time required, we will not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, except in the absence of legal capacity, the proof required must be given no later than one year from the time specified.

Payment of Benefits
Benefits will be paid as soon as the necessary proof to support the claim is received, but no later than 60 days after receipt of loss. Written proof must be provided for all benefits.

Records of expenses
You should keep complete records of your expenses. They may be needed for a claim.

Things that would be important to keep are:

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

Honest mistakes and intentional deception
Honest mistakes
You or your employer may make an honest mistake in your application for coverage. 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.

After two years from the date of this Policy, only fraudulent misstatements in an application may be used to void the policy or deny any claim for loss incurred or disability (as defined in the policy) that starts after the two-year period.

Intentional deception

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

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

We also may report fraud to criminal authorities.

You have special rights if we rescind your coverage.

- We will give you 30 days advanced written notice of any rescission of coverage.
- We will refund you all premium you paid.
- You have the right to an appeal. See When you disagree - claim decisions and appeal procedures, Appeal of adverse benefit determination 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 **ambulance** services, we will not accept an assignment to an **out-of-network provider**.

Recovery of overpayments

We sometimes pay too much for **eligible health 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. Health information is information that identifies you and relates to your medical history. We use and share it to help us process your claims and manage your policy. You can get a free copy of our Notice of Privacy Practices. Just call Member Services at the toll-free number on your ID card.

Glossary

Ambulance
A vehicle staffed by medical personnel and equipped to transport an ill or injured person.

Behavioral health provider
An individual professional that is licensed or certified to provide diagnostic and/or therapeutic services for **mental disorders** and **substance use disorder** under the laws of the jurisdiction where the individual practices.

Biosimilar prescription drug
A biological **prescription drug** that is highly similar to a U.S. Food and Drug Administration (FDA) – licensed reference biological **prescription drug**, even though there may be minor differences in clinically inactive components, and for which there are no clinically meaningful differences between the highly similar biological **prescription drug** and the reference biological **prescription drug** in terms of the safety, purity, and potency of the drug. As defined in accordance with U.S. Food and Drug Administration (FDA) regulations.

Brand-name prescription drug
An FDA approved **prescription drug** with a branded name assigned to it by the manufacturer or distributor, and indicated by Medi-span or similar publication designated by us.

Calendar year
A period of 12 months that begins on January 1st and ends on December 31st.

Coinsurance
The specific percentage you have to pay for a health care service listed in the schedule of benefits.

Copay, copayments
The specific dollar amount you have to pay for a health care service listed in the schedule of benefits. **Copayments** may be changed by us upon 30 days written notice to the **policyholder**.

Cosmetic
Services, drugs or supplies that are primarily intended to alter, improve or enhance your appearance.

Covered benefits
Eligible health services that meet the requirements for coverage under the terms of this plan.

Custodial care
Services and supplies mainly intended to help meet your activities of daily living or other personal needs. Care may be **custodial care** even if it is prescribed by a **physician** or given by trained medical personnel.

Deductible
The amount you pay for **eligible health services** per **plan year** before your plan starts to pay as listed in the schedule of benefits.

Dental provider
Any individual legally qualified to provide dental services or supplies.

Detoxification
The process where an alcohol or drug intoxicated or dependent person is assisted through the period needed to eliminate the:

- Intoxicating alcohol or drug
- Alcohol or drug-dependent factors
- Alcohol in combination with drugs

This can be done by metabolic or other means determined by a **physician**. The process must keep the physiological risk to the patient at a minimum. And if it takes place in a facility, the facility must meet any applicable licensing standards established by the jurisdiction in which it is located.

Directory
The list of **network providers** for your plan. The most up-to-date **directory** for your plan appears at www.innovationhealth.com. When searching www.innovationhealth.com you need to make sure that you are searching for **providers** that participate in your specific plan. **Network providers** may only be considered for certain plans. When searching for network **dental providers**, you need to make sure you are searching under dental plan.

Durable medical equipment (DME)
Equipment and the accessories needed to operate it, that is:

- Made to withstand prolonged use
- Mainly used in the treatment of an **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

Effective date of coverage
The date you and your dependents coverage begins under this booklet-certificate as noted in our records.

Eligible health services
The health care services and supplies listed in the *Eligible health services under your plan* section and not listed or limited in the *Exceptions* section or above limits shown in the schedule of benefits**.**

Emergency medical condition

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

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

Emergency services

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

Stabilize means providing treatment that guarantees 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

A drug, device, procedure, or treatment that we find is **experimental or investigational** because:

- 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**.
- It is provided or performed in a special setting for research purposes.

Generic prescription drug, generic drug

A **prescription drug**, whether identified by its chemical, proprietary, or non-proprietary name, that is accepted by the U.S. Food and Drug Administration (FDA) as therapeutically equivalent and interchangeable with a drug having an identical amount of the same active ingredient and so indicated by Medi-span or similar publication designated by **us**.

Health professional

A person who is licensed, certified or otherwise authorized by law to provide health care services to the public. For example, **physicians**, nurses, and physical therapists.

Home health care agency

An agency licensed, certified or otherwise authorized by applicable state and federal laws to provide home health care services, such as skilled nursing and other therapeutic services.

Home health care plan
A plan of services prescribed by a **physician** or other health care practitioner to be provided in the home setting. These services are usually provided after your discharge from a **hospital** or if you are homebound.

Hospice care
Care designed to give supportive physical, psychological, psychosocial or other health care services to people with a **terminal illness** and focus on comfort and quality of life, rather than cure.

Hospice care agency
An agency or organization licensed, certified or otherwise authorized by applicable state and federal laws to provide **hospice care**. These services may be available in your home or inpatient setting.

Hospice care program
A program prescribed by a **physician** or other **health professional** to provide **hospice care** and support to a person with a terminal illness and their families.

Hospice facility
An institution specifically licensed, certified or otherwise authorized by applicable state and federal laws to provide **hospice care**.

Hospital
An institution licensed as a **hospital** by applicable state and federal laws, and is accredited as a **hospital** by The Joint Commission (TJC).

Hospital does not include a:

- Convalescent facility
- Rest facility
- Nursing facility
- Facility for the aged
- **Psychiatric hospital**
- **Residential treatment facility** for **substance use disorder**
- **Residential treatment facility** for **mental disorders**
- Extended care facility
- Intermediate care facility
- **Skilled nursing facility**

Illness
A sickness or disease of the body or mind.

Infertile or infertility
A disease defined by the failure to conceive a pregnancy after 12 months or more of timed intercourse or egg-sperm contact for women under age 35 (or 6 months for women age 35 or older).

Injury
Physical damage done to a person or part of their body.

Innovation Health Insurance Company
Innovation Health Insurance Company, an affiliate, or a third party vendor under contract with us.

Institutes of Excellence™ (IOE) facility
A facility designated by us in the **provider directory** as Institutes of Excellence **network provider** for specific services or procedures.

Intensive outpatient program (IOP)
Clinical treatment provided in a facility or program provided under the direction of a **physician**. Services are designed to address a **mental disorder** or **substance use disorder** issue and may include group, individual, family or multi-family group psychotherapy, psycho educational services, and adjunctive services such as medication monitoring.

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.

L.P.N.
A licensed practical nurse or a licensed vocational nurse.

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

Maximum out-of-pocket limit
The maximum out-of-pocket amount for payment of **copayments** and **coinsurance** including any **deductible** if it applies, that you or any covered dependents pay per **plan year** for **eligible health services**.

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

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

Generally accepted standards of medical practice means:

- Standards based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community.
- Consistent with the standards set forth in policy issues involving clinical judgment.

Mental disorder

An **illness** commonly understood to be a **mental disorder**, whether or not it has a physiological or organic basis, and for which treatment is generally provided by or under the direction of a **behavioral health provider** such as a **psychiatrist**, a psychologist or a psychiatric social worker. Any one of the following conditions is a **mental disorder** under this plan:

- Anorexia/Bulimia Nervosa
- Bipolar disorder
- Major depressive disorder
- Obsessive compulsive disorder
- Panic disorder
- Pervasive Mental Developmental Disorder (including Autism)
- Psychotic Disorders/Delusional Disorder
- Schizo-afftective Disorder
- Schizophrenia
- Emotional or nervous disorders

This also includes any other mental condition which requires **medically necessary** treatment.

Morbid obesity

This means the body mass index is well above the normal range (greater than 40 kilograms per meter squared; or equal to or greater than 35 kilograms per meter squared) and severe medical conditions may also be present, such as:

- High blood pressure
- A heart or lung condition
- Sleep apnea
- Diabetes

Body mass index is a degree of obesity and is calculated by dividing your weight in kilograms by your height in meters squared.

Negotiated charge

*As to medical coverage, (other than **prescription drug** coverage):*
The maximum amount a **network provider** has agreed to accept for rendering services or providing supplies to members of your plan.

The **negotiated charge** does not reflect any amount an affiliate or we may receive under a rebate arrangement between us or an affiliate and a drug manufacturer for any **prescription drug**.

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

*As to **prescription drug** coverage:*
This only applies to in-network coverage and is the amount we established for each **prescription drug** obtained from a **network pharmacy** under this plan. This **negotiated charge** may reflect amounts we agreed to pay directly to the **network pharmacy** or to a third party vendor for the **prescription drug**, and may include an additional service or risk charge set by us.

The **negotiated charge** does not reflect any amount an affiliate or we may receive under a rebate arrangement between us an affiliate or a third party vendor and a drug manufacturer for any **prescription drug**, including **prescription drugs** on the **preferred drug guide**.

We may receive rebates from the manufacturers of **prescription drugs** and may receive or pay additional amounts from or to third parties under price guarantees. These amounts will not change the **negotiated charge** under this plan.

Network provider
A **provider** listed in the **directory** for your plan. However, a National Advantage Program (NAP) provider listed in the NAP **directory** is not a **network provider**.

Network pharmacy
A **retail**, **mail order** or **specialty pharmacy** that has contracted with us, an affiliate, or a third party vendor, to provide outpatient **prescription drugs** to you. **Network pharmacies** include **out-of-network** pharmacies that have agreed by fax or otherwise to accept our payment as payment in full.

Non-preferred drug
A **prescription drug** or device that is not listed in the **preferred drug guide**.

Out-of-network provider
A **provider** who is not a **network provider** and does not appear in the **directory** for your plan.

Partial hospitalization treatment
A day or evening treatment program that includes the major diagnostic, medical, psychiatric, and psychosocial rehabilitation treatment modalities to treat **mental disorder** and **substance use disorder**. The treatment plan must meet these tests:

- It is treatment over a period of six or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients.
- It is in accordance with accepted medical practice for the condition of the person.
- It does not require full-time confinement.
- It is supervised by a **psychiatrist** who weekly reviews and evaluates its effect.

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

Pharmacy
An establishment where **prescription drugs** are legally dispensed. This can be a **retail**, **mail order** and **specialty pharmacy**.

Physician
A skilled health care professional trained and licensed to practice 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)**.

Plan Year
A consecutive 12 month period during which the plan provides coverage for **covered benefits**.

Policyholder
An employer or organization who agrees to remit the **premiums** for coverage under the group policy payable to us. The **policyholder** shall act only as our agent of **members** in the employer group, and shall not be the agent of ours for any purpose.

Precertification, precertify
A requirement that you or your **physician** contact us before you receive coverage for certain 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 is listed on the **preferred drug guide**.

Preferred 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 of the **preferred drug guide** is available at your request. Or you can find it on our website at www.innovationhealth.com/formulary.

Premium
The amount you or your employer is required to pay to us for your coverage.

Prescriber
Any **provider** acting within the scope of his or her license, who has the legal authority to write an order for outpatient **prescription drugs**.

Prescription
As to hearing care:
A written order for the dispensing of **prescription** electronic hearing aids by otolaryngologist, otologist or audiologist.

*As to **prescription drugs**:*
A written order for the dispensing of a **prescription drug** by a **prescriber**. If it is a verbal order, it must promptly be put in writing by the **network pharmacy**.

As to vision care:
A written order for the dispensing of **prescription** lenses or **prescription** contact lenses by an ophthalmologist or optometrist.

Prescription drug
A drug, biological, or compounded **prescription** which, by state and federal law, may be dispensed only by **prescription** or administered by a person who is acting within his or her capacity as a paid **health professional**.

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

- The **directory** lists as a **PCP**
- Supervises, coordinates and provides initial care and basic medical services to a person as a family care **physician,** an internist or a pediatrician
- Is shown on our records as your **PCP**

Provider
A **physician**, other **health professional**, **hospital**, **skilled nursing facility**, **home health care agency** or other entity or person licensed or certified under applicable state and federal law to provide health care services to you. If state law does not specifically provide for licensure or certification, the entity must meet all Medicare accreditation standards (even if it does not participate in Medicare).

Psychiatric hospital
An institution specifically licensed as a **psychiatric hospital** by applicable state and federal laws to provide a program for the diagnosis, evaluation, and treatment of alcoholism, drug abuse, **mental disorders**, or mental **illnesses**.

Psychiatrist
A **psychiatrist** generally provides evaluation and treatment of mental, emotional, or behavioral disorders.

Recognized charge
The amount of an **out-of-network provider's** charge that is eligible for coverage. You are responsible for all amounts above the **recognized charge**. The **recognized charge** may be less than the **provider's** full charge.

In all cases, the **recognized charge** is based on the geographic area where you receive the service or supply.

Except as otherwise specified below, the **recognized charge** for each service or supply is the lesser of what the **provider** bills and:

- For professional services and for other services or supplies not mentioned below:
  - 90% of the Medicare allowable rate
- For services of **hospitals** and other facilities:
  - 90% of the Medicare allowable rate
- For prescription drugs:
  - 50% of the Average wholesale price (AWP)
- For dental expenses:
  - 80% of the prevailing charge rate

We have the right to apply our reimbursement policies. Those policies may further reduce the **recognized charge.** These policies take into account factors such as:

- The duration and complexity of a service
- When multiple procedures are billed at the same time, whether additional overhead is required
- Whether an assistant surgeon is necessary for the service
- If follow up care is included
- Whether other characteristics modify or make a particular service unique
- When a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided and
- The educational level, licensure or length of training of the **provider**

Our reimbursement policies are based on our review of:

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

We use commercial software to administer some of these policies. Some policies are different for professional services than for facility services.

Special terms used
Average wholesale price (AWP), Geographic area, Medicare allowable rates, Prevailing charge rates are defined as follows:

Average wholesale price (AWP)
Is the current average wholesale price of a **prescription drug** listed in the Facts and Comparisons, Medi-span weekly price updates (or any other similar publication chosen by us).

Geographic area
The Geographic area made up of the first three digits of the U.S. Postal Service zip codes. If we determine we need more data for a particular service or supply, we may base rates on a wider Geographic area such as an entire state.

Medicare allowable rates
Except as specified below, these are the rates CMS establishes for services and supplies provided to Medicare enrollees. We update our systems with these revised rates within 180 days of receiving them from CMS. If Medicare does not have a rate, we will determine the rate as follows:

- Use the same method CMS uses to set Medicare rates.
- Look at what other **providers** charge.
- Look at how much work it takes to perform a service.
- Look at other things as needed to decide what rate is reasonable for a particular service or supply.

Prevailing charge rates
The percentile value reported in a database prepared by FAIR Health, a nonprofit company. FAIR Health changes these rates periodically. We update our systems with these changes within 90 days after receiving them from FAIR Health. If the Fair Health database becomes unavailable, we have the right to substitute an alternative database that we believe is comparable.

Additional information:
Get the most value out of your benefits. Use the "Estimate the Cost of Care" tool to help decide whether to get care in network or out-of-network. Our secure member website at www.innovationhealth.com may contain additional information which may help you determine the cost of a service or supply. Log on to www.innovationhealth.com to access the "Estimate the Cost of Care" feature. Within this feature, view our "Cost of Care" and "Member Payment Estimator" tools.

R.N.
A registered nurse.

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

Residential treatment facility (mental disorder, including mood disorders and eating disorders)

- An institution specifically licensed as a **residential treatment facility** by applicable state and federal laws to provide for mental health residential treatment programs. And is credentialed by us or is accredited by one of the following agencies, commissions or committees for the services being provided:
  - The Joint Commission (TJC)
  - The Committee on Accreditation of Rehabilitation Facilities (CARF)
  - The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP)
  - The Council on Accreditation (COA)

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

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

Residential treatment facility (substance use disorder including drugs and alcohol)

- An institution specifically licensed as a residential treatment facility by applicable state and federal laws to provide for **substance use disorder** residential treatment programs. And is credentialed by us or 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 Chemical Dependence 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**.
- Is not a wilderness treatment program (whether or not the program is part of a licensed **residential treatment facility** or otherwise licensed institution).

In addition to the above requirements, for Chemical Dependence **Detoxification** Programs within a residential setting:

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

Retail pharmacy

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

Room and board

A facility's charge for your overnight **stay** and other services and supplies expressed as a daily or weekly rate. **Room and board** includes the following **eligible health services**:

- Bed
- Meals
- Special diets
- Semi-private room rate
- Private room when **medically necessary**

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.

Service area
The geographic area where **network providers** for this policy are located.

Skilled nursing facility
A facility specifically licensed as a **skilled nursing facility** by applicable state and federal laws to provide skilled nursing care.

Skilled nursing facilities also include rehabilitation **hospitals** and portions of a rehabilitation **hospital** and a **hospital** designated for skilled or **rehabilitation services**.

Except for **Hospice care, skilled nursing facility** does not include institutions that provide only:

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

It does not include institutions that primarily provide for the care and treatment of **mental disorders** or **substance use disorder**.

Skilled nursing services
Services provided by an **R**.**N**. or **L.P.N.** within the scope of his or her license.

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

Specialty prescription drugs
These are **prescription drugs** that include self-injectable, injectable, infusion and oral drugs prescribed to address complex, chronic diseases with associated illnesses such as:

- Cancer
- Rheumatoid arthritis
- Hemophilia
- Human immunodeficiency virus infection
- Multiple sclerosis

You can access the list of these **specialty prescription drugs.** See the *How to contact us for help* section for details.

Specialty pharmacy
This is a **pharmacy** designated to fill **prescriptions** for self-injectable drugs and **specialty prescription drugs**.

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

Step therapy
A form of **precertification** under which certain **prescription drugs** will be excluded from coverage, unless a first-line therapy drug(s) 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** shall be available upon request by you or may be accessed on our website at www.innovationhealth.com/formulary.

Substance use disorder
This is a physical or psychological dependency, or both, on a controlled substance or alcohol agent.

Surgery center
A facility specifically licensed as a freestanding ambulatory surgical facility by applicable state and federal laws to provide outpatient **surgery** services. If state law does not specifically provide for licensure as an ambulatory surgical facility, the facility must meet all Medicare accreditation standards (even if it does not participate in Medicare).

Surgery or surgical procedures
The diagnosis and treatment of **injury**, deformity and disease by manual and instrumental means. This includes:

- Cutting
- Scraping
- Suturing
- Destruction
- Removal
- Lasering

It also includes:

- Introduction of a catheter (e.g., heart or bladder catheterization) or scope (e.g., colonoscopy, endoscopy)
- Correction of fracture
- Reduction of dislocation
- Application of plaster casts
- Injection into a joint or injection of sclerosing solution
- Physically changing body tissues and organs

Telemedicine
The use of interactive audio, video, or other electronic technology or media used for the purpose of diagnosis, consultation, or treatment.

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

Therapeutic drug class
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**.

Tier 1A - value drugs
A group of medications determined by us that may be available at a reduced **copayment/coinsurance** and are noted on the **preferred drug guide** on our website at www.innovationhealth.com/formulary.

Urgent care facility
A facility licensed as a freestanding medical facility by applicable state and federal laws to treat an **urgent condition**.

Urgent condition
An **illness** or **injury** that requires prompt medical attention but is not an **emergency medical condition**.

Walk-in clinic
A free-standing health care facility. Neither of the following is considered a **walk-in clinic**:

- An emergency room
- The outpatient department of a **hospital**

Discount programs

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 or services they deliver. We are not responsible. But, 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 the discounted goods or services.

Wellness and other incentives

We may encourage and incent you to access certain medical services, to use online tools that enhance your coverage and services, and to continue participation as a member. You and your doctor can talk about these medical services and decide if they are right for you. We may also encourage and incent you in connection with participation in a wellness or health improvement program. Incentives include but are not limited to:

- Modification to **copayment**, **deductible** or **coinsurance** amounts
- **Premium** discounts or rebates
- Contributions to health savings account
- Fitness center membership reimbursement
- Merchandise
- Coupons
- Gift cards
- Debit cards
- Any combination of the above

The award of any such incentive shall not depend upon the result of a wellness or health improvement activity or upon a member's health status.

Innovation Health Insurance Company

Booklet-Certificate Amendment

Effective Date: 01/01/2018

This amendment is part of your booklet-certificate. It is effective on the date shown above.

Who the plan covers is revised as follows:

The **Who can be on your plan (who can be your dependent)** section is deleted in its entirety and replaced with the following:

Who can be on your plan (who can be your dependent)

If your plan includes coverage for dependents, you can enroll the following family members on your plan. (They are your "dependents".)

- Your legal spouse
- Your domestic partner who meets eligibility rules set by your employer
- Your dependent children – your own or those of your spouse or domestic partner
  The children must be under 26 years of age and they include your:
  - Biological children
  - Stepchildren
  - Legally adopted children, including any children placed with you for adoption
  - Foster children
  - Children you are responsible for under a qualified medical support order or court-order (whether or not the child resides with you)
  - Grandchildren in your court-ordered custody

The **Effective date of coverage** section is deleted in its entirety and replaced with the following:

Effective date of coverage

Your coverage will begin after we have received your completed enrollment form. Depending on when you enroll, the start date will be either:

- On the date the **policyholder** tells us
- As described under *Special times you can join the plan* (later in this section)

Dependent coverage will start:

- On your effective date, if you enrolled them at that time.
- Generally, the first day of the month based on when we receive your completed enrollment form, if you enrolled them at another time. See *Adding new dependents* and *Special times you can join the plan* for more information.

The **Adding new dependents** section is deleted in its entirety and replaced with the following:

Adding new dependents

If your plan includes coverage for dependents, you can add the following new dependents to your plan:

- A spouse - If you marry, you can put your spouse on your plan.
  - We must receive your completed enrollment information not more than 31 days after the date of your marriage.
  - Ask your employer when benefits for your spouse will begin:
    - If we receive your completed enrollment information by the 15th of the month, coverage will be effective no later than the first day of the following month.
    - If we receive your completed enrollment information between the 16th and the last day of the month, coverage will be effective no later than the first day of the second month.
- A domestic partner - If you enter a domestic partnership, you can enroll your domestic partner on your plan. See *Who can be on your plan (Who can be your dependent)* section for more information.
  - We must receive your completed enrollment information not more than 31 days after the date you file a Declaration of Domestic Partnership, or not later than 31 days after you provide documentation required by your employer.
  - Ask your employer when benefits for your domestic partner will begin. It will be on the date your Declaration of Domestic Partnership is filed or the first day of the month following the qualifying event date.
- A newborn child - Your newborn child is covered on your health plan for the first 31 days after birth.
  - To keep your newborn covered, we must receive your completed enrollment information within 31 days of birth.
  - You must still enroll the child within 31 days of birth even when coverage does not require payment of an additional **premium** contribution for the covered dependent.
  - If you miss this deadline, your newborn will not have health benefits after the first 31 days.
- An adopted child - You may put an adopted child on your plan when the adoption is complete or the date the child is placed for adoption. “Placed for adoption” means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child.
  - You must complete your enrollment information and send it to us within 31 days after the adoption or the date the child was placed for adoption.
  - Ask your employer when benefits for your adopted child will begin. It is usually the date of the adoption (or placement) or the first day of the month following adoption (or placement). A child whose adoption or placement for adoption occurs within thirty-one days of birth will be considered a newborn child as of the date of the adoption or placement for adoption.

- A foster child – You may put a foster child on your plan when you have obtained legal responsibility as a foster parent. A foster child is a child whose care, comfort, education and upbringing are left to persons other than the natural parents.
    - You must complete your enrollment information and send it to us within 31 days after the date the child is placed with you.
    - Ask your employer when benefits for your foster child will begin. It is usually the date you legally become a foster parent or the first day of the month following this event.
- A stepchild - You may put a child of your spouse or domestic partner on your plan.
    - You must complete your enrollment information and send it to us within 31 days after the date of your marriage or declaration of domestic partnership with your stepchild's parent.
    - Ask your employer when benefits for your stepchild will begin. It is the date of your marriage or declaration of domestic partnership or the first day of the month following the qualifying event date.
- Court order – You can put a child you are responsible for under a qualified medical support order or court order on your plan.
    - You must complete your enrollment information and send it to us within 31 days after the date of the court order.
    - Ask your employer when benefits for the child will begin. It is usually the date of the court order or the first day of the month following the qualifying event date.

The **Special times you can join the plan** section is revised to change the title to **Special times you or your dependent can join the plan**. All references to this section are revised accordingly. The section is deleted in its entirety and replaced with the following:

Special times you or your dependent can join the plan

Federal law allows you and your dependents, if your plan includes coverage for dependents, to enroll at times other than your employer's annual open enrollment period. This is called a special or limited enrollment period.

You can enroll in these situations when:

- You have added a dependent because of marriage, birth, adoption or foster care. See the *Adding new dependents* section for more information.
- You or your dependent qualify for access to new plans because you have moved to a new permanent location.
- You or your dependent did not enroll in this plan before because:
    - You were covered by another health plan, and now that other coverage has ended.
    - You had COBRA, and now that other coverage has ended.
- A court orders you to cover a current spouse or domestic partner or a child on your health plan.
- You or your dependent lose your eligibility for enrollment in Medicaid or an S-CHIP plan.
- You or your dependent become eligible for State **premium** assistance under Medicaid or an S-CHIP plan for the payment of your **premium** contribution for coverage under this plan.

We must receive your completed enrollment information from you within 31 days of the event or the date on which you no longer have the other coverage mentioned above. However, the completed enrollment form may be submitted within 60 days of the event when:

- You lose your eligibility for enrollment in Medicaid or an S-CHIP plan Medicaid
- You become eligible for State **premium** assistance under Medicaid or an S-CHIP plan for the payment of your **premium** contribution for coverage under this plan

Effective date of coverage

Your coverage will be in effect based on when we receive your completed enrollment application:

- No later than the first day of the following month if completed enrollment information is received by the 15th of the month
- No later than the first day of the second month if completed enrollment information is received between the 16th and the last day of the month
- In accordance with the effective date of a court order
- An appropriate date based on the circumstances of the special enrollment period

Medical necessity and precertification requirements has been revised as follows:
The following services are added to the list of services requiring precertification:

Non-emergency transportation by fixed wing airplane
Transcranial magnetic stimulation (TMS)
Psychological testing\neuropsychological testing
Applied behavior analysis
Intensive outpatient program (IOP) – **mental disorder** and **substance use disorder** diagnoses
Outpatient detoxification
Partial hospitalization treatment – **mental disorder** and **substance use disorder** diagnoses

The following services are removed from the list of services requiring precertification:

Emergency transportation by airplane
Wrist surgery

Eligible health services under your plan is revised as follows:

The **Important note** in the **Preventive care and Wellness** section is deleted and replaced with the following:

Important notes:
1. You will see references to the following recommendations and guidelines in this section:
   - Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
   - United States Preventive Services Task Force
   - Health Resources and Services Administration
   - American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents

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

2. Diagnostic testing is not covered under the preventive care benefit. You will pay the cost sharing specific to **eligible health services** for diagnostic testing.

3. Gender-specific preventive care benefits include **eligible health services** described below regardless of the sex you were assigned at birth, your gender identity, or your recorded gender.

4. To learn what frequency and age limits apply to routine physical exams and routine cancer screenings, contact your **physician** or see the *How to contact us for help* section. This information can also be found at the www.healthcare.gov website. For a detailed listing of preventive care services described in this section refer to https://www.healthcare.gov/prevention/.

Other services and supplies that your physician may provide in the above listed settings in the **Physician and other health professionals** section is revised to add the following:

- Diagnostic hearing and vision tests

The last sentence in the **Home health care** section is revised as follows to remove the reference to applied behavior analysis:
Home health care services do not include **custodial care.**

The **Autism spectrum disorder** section is revised to add the following:
We will cover certain early intensive behavioral interventions such as applied behavior analysis. Applied behavior analysis is an educational service that is the process of applying interventions:

- That systematically change behavior
- That are responsible for observable improvements in behavior

Important note:
Applied behavior analysis requires **precertification** by **us**. The **network provider** is responsible for obtaining **precertification**.

The **Mental health treatment** section is revised to add the following outpatient services:

Outpatient telemedicine consultation
Transcranial magnetic stimulation (TMS)
Neuropsychological testing
23 hour observation

The **Substance use disorder treatment** section is revised to add the following outpatient services:

- Outpatient telemedicine consultation
- Outpatient detoxification
- Treatment of withdrawal symptoms
- 23 hour observation
- Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
    - You are homebound
    - Your physician orders them
    - The services take the place of a stay in a hospital or a residential treatment facility, or you are unable to receive the same services outside your home
    - The skilled behavioral health care is appropriate for the active treatment of a condition, illness or disease to avoid placing you at risk for serious complications

The **Transplant services** section is revised to add the following information:
Eligible health services include travel and lodging expenses for you and your companion to travel between your home and the IOE facility to receive services in connection with an approved transplant procedure or treatment. If the member receiving care is a minor, transportation and lodging may be allowed for two companions. Transportation and lodging costs for the donor are also covered when the donor is member.

The **Reconstructive surgery and supplies** section deleted in its entirety and replaced with the following:

Reconstructive surgery and supplies

Eligible health services include all stages of reconstructive **surgery** 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 even with the reconstructed breast, treatment of physical complications of all stages of the mastectomy, including lymphedema, and prostheses. These can be done at the same time as the mastectomy or later. **Eligible health services** for reconstructive breast surgery include**:**
    - 48 hours of inpatient care following a radical or modified radical mastectomy
    - 24 hours of inpatient care after a total or partial mastectomy with lymph node dissection for treatment of breast cancer.
- Your **surgery** corrects an accidental **injury**. **Injuries** that occur during medical treatments are not considered accidental **injuries**, even if unplanned or unexpected. **Surgery** to fix teeth injured due to an accident is covered when:
    - Teeth are sound natural teeth.
    - The **surgery** must be performed within 12 months or as soon after that as possible.
- Your **surgery** is needed to improve a significant functional impairment of a body part.
- Your **surgery** corrects a birth defect or other significant deformity caused by illness, injury or a previous treatment. The **surgery** will be covered if:
    - The defect results in severe facial disfigurement or major functional impairment of a body part.
    - The purpose of the **surgery** is to improve function.

Specific therapies and tests is revised as follows:

The Early intervention services section is revised to add the following language:
Eligible health services are not limited by the exclusion of services that are not **medically necessary**.

Rehabilitation and habilitation services is deleted in its entirety and replaced with the following sections:

Rehabilitation services

Rehabilitation services help you restore or develop skills and functioning for daily living. **Eligible health services** include rehabilitation services your **physician** prescribes. 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**

Rehabilitation services have to follow a specific treatment plan ordered by your **physician**.

Outpatient physical, occupational and speech therapy and cognitive rehabilitation

Eligible health services include:

- Physical therapy, but only if it is expected to ease pain, restore health, and avoid disability after an **illness**, **injury** or **surgical procedure** or loss of limb, or to treat lymphedema Including:
  - Hydrotherapy
  - Heat
  - Physical agents
  - Bio-mechanical and neuro-physiological principles and devices
- Occupational therapy (except for vocational rehabilitation or employment counseling), but only if it is expected to:
  - Significantly improve, develop or restore physical functions you lost as a result of an acute **illness**, **injury** or **surgical procedure** such as walking, eating, drinking, dressing, toileting, transferring from wheelchair to bed, bathing, and job related activities.
  - Relearn skills so you can significantly regain your ability to perform the activities of daily living on your own.
- Speech therapy, but only if it is expected to:
  - Significantly improve or restore speech function or correct a speech impairment as a result of an acute **illness**, **injury** or **surgical procedure**.
  - Improve delays in speech function development caused by a gross anatomical defect present at birth.
  - Identify, assess, and treat speech function, language, speech impairment and swallowing disorders in children and adults.
  - Treat communication or swallowing difficulties to correct a speech impairment

  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.

Habilitation therapy services

Habilitation therapy services are services that 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).

Eligible health services include habilitation therapy services your **physician** prescribes. The services have to be provided by a:

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

Habilitation therapy services have to follow a specific treatment plan ordered by your **physician**.

Outpatient physical, occupational, and speech therapy

Eligible health services include:

- Physical therapy (except for services provided in an educational or training setting)
- Occupational therapy (except for vocational rehabilitation or employment counseling or services provided in an educational or training setting)
- Speech therapy (except for services provided in an educational or training setting or to teach sign language)

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

Other services is revised as follows:

The section title **Nutritional supplements** is changed to **Nutritional support**. All references to this section are revised accordingly. There are no other changes to this provision.

Routine vision exams in the **Vision care, Pediatric vision care** section is deleted in its entirety and replaced with the following:

Routine vision exams

Eligible health services include a complete examination complete routine eye exam with dilation provided by an ophthalmologist or optometrist. The exam is used to check all aspects of your vision including refraction and glaucoma testing.

Vision care services and supplies in the **Vision care, Pediatric vision care** section is deleted in its entirety and replaced with the following:

Vision care supplies

We provide vision eyewear coverage that can help pay for **prescription** eyeglasses or **prescription** contact lenses. You have access to an extensive network of vision locations. If you have questions, see the *How to contact us for help* section.

Eligible health services include:

- Eyeglass frames,
- **Prescription** lenses, including
    - Choice of glass or plastic
    - All lens powers (single vision, bifocal, trifocal, lenticular and standard progressives)
    - Scratch resistant coating
- **Prescription** contact lenses including
    - Elective Contact Lenses –chosen for comfort or appearance
    - Non-Elective Contact Lenses – Only prescribed for certain eye conditions:
        - Keratoconus when your vision is not correctable to 20/40 in either or both eyes using standard spectacle lenses.
        - High Ametropia exceeding -12D or +9D in spherical equivalent.
        - Anisometropia of 3D or more.
        - When your vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

Special Note: **Eligible health services** do not include non-elective contact lenses if you have undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

In any one year, this benefit will cover either **prescription** lenses for eyeglass frames or **prescription** contact lenses, but not both.

The section title **Vision correction after Surgery or Accident** is changed **Vision correction after Surgery or for illness or Accident.** The section is revised to add coverage for the following services:

- Low vision services and supplies, including prescribed optical devices, such as high-powered spectacles, magnifiers and telescopes.

Outpatient prescription drugs is revised as follows:

The **Eligible health services under your plan** section is revised to add the following:
Your outpatient **prescription drug** plan is based on the drugs in the **drug guide**. The **drug guide** includes both **brand-name prescription drugs** and **generic prescription drugs**.

Your pharmacist may substitute **generic prescription drugs** for **brand-name prescription drugs**. Your out-of-pocket costs may be less if you use a **generic prescription drug** when available.

You can call us at the number on your ID card or log on to your Navigator® secure member website at www.innovation-health.com to see if a **prescription drug** that is not listed on the **drug guide** is covered.

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

- Limiting coverage of the applicable drug(s) to one prescribing **provider** and/or one **network pharmacy**
- Limiting the quantity, dosage or day supply
- Requiring a partial fill or denial of coverage

The **Retail pharmacy** section is revised to delete the following sentence:
All prescriptions and refills over a 30 day supply must be filled at a network mail order pharmacy.

The **Risk reducing breast cancer prescription drugs** section in the **Other services** section is deleted and replaced with the following:

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

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

What your plan doesn't cover – eligible health service exceptions and exclusions is revised as follows:

The following exclusions are deleted:

Autism spectrum disorder
Habilitation therapy services
Rehabilitation services
Specialty prescription drugs
Under **Outpatient prescription drugs**
- Prophylactic drugs for travel

Under **Home health care**
- Applied behavior analysis

The following exclusions are deleted in their entirety and replaced with new language:

Educational services

Examples of those services are:

- Any service or supply for education, training or retraining services or testing. This includes special education, remedial education, wilderness treatment program, job training and job hardening programs.
- Services provided by a school district.

This exception does not apply to diabetes or lymphedema training, early intervention services or any educational services covered under *Eligible health services under your plan* – Preventive care and wellness.

Mental health treatment/ substance use treatment

- Mental health services for the following categories (or equivalent terms as listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM)):
  - Stay in a facility for treatment for dementias or amnesia without a behavioral disturbance that necessitates mental health treatment
  - Sexual deviations and disorders except for gender identity disorders
  - Tobacco use disorders
  - Pathological gambling, kleptomania, pyromania
  - School and/or education service, including special educational, remedial education, wilderness treatment programs or any such related or similar programs
- Services provided in conjunction with school, vocation, work or recreational activities
- Transportation

Vision care

Pediatric vision care services and supplies

Your plan does not cover vision care services and supplies, except as described in the *Eligible health services under your plan – Other services* section.

- Special supplies such as non-**prescription** sunglasses
- Non-**prescription** eyeglass frames, non-**prescription** lenses and non-**prescription** contact lenses
- Special vision procedures, such as orthoptics or vision therapy
- Eye exams during your **stay** in a **hospital** or other facility for health care
- Eye exams for contact lenses or their fitting

- Acuity tests
- Eye **surgery** for the correction of vision, including radial keratotomy, LASIK and similar procedures

The following exclusion is revised:
Allergy serum and extracts under **Outpatient prescription drugs**
Allergy serum and extracts administered by injection- for medical coverage see the ***Eligible health services*** *under your plan-Physicians and other health professionals* section.

The following exclusion is added:
Early intensive behavioral interventions
Examples of those services are:

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

Under **Outpatient prescription drugs:**

- Compound **prescriptions** containing bulk chemicals when the main ingredient has not been approved by the U.S. Food and Drug Administration (FDA). This includes compounded bioidentical hormones.

When you disagree - claim decisions and appeal procedures is revised as follows:

The **Exhaustion of appeal process section** is deleted in its entirety and replaced with the following:

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 level appeals process before you may take other actions. These are when:

- You have an urgent pre-service claim or a claim that involves ongoing treatment. You can have your claim reviewed internally and at the same time through the external review process.
- We did not follow all of the claim determination and appeal requirements of the State or Federal Department of Health and Human Services. 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 **External review section** is deleted in its entirety and replaced with the following:

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:

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

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.

We will stand by the decision that the IRO makes, unless we can show conflict of interest, bias or fraud.

How long will it take to get an IRO decision?

We will tell you of 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 call us or send us a Request for External Review Form. There are two scenarios when you may be able to get a faster external review:

For initial adverse determination

Your **provider** tells us that a delay in your receiving health care services would:

- Jeopardize your life, health or ability to regain maximum function
- Be much less effective if not started right away (usually for **experimental or investigational** treatment)

For final adverse determination

Your **provider** tells us that a delay in your receiving health care services would:

- Jeopardize your life, health or ability to regain maximum function
- Be much less effective if not started right away (**experimental or investigational** treatment)
- 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 us getting your request.

When coverage ends is revised as follows:

Why would we end coverage? is deleted in its entirety and replaced with the following:

Why would we end coverage?

We may immediately end your coverage if you commit fraud or intentionally misrepresent yourself when you applied for or obtained coverage. If your coverage is rescinded, 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 prepayments for periods after the date your coverage ended.

When coverage may continue under the plan is deleted in its entirety and replaced with the following:

When coverage may continue under the plan

Your coverage under this plan will continue if:

Your employment ends because: • Your job has been eliminated • You have been placed on severance • This plan allows former employees to continue their coverage	You may be able to continue coverage. See the *Special coverage options after your coverage ends* section.
Your employment ends because of a military leave of absence.	If **premium** payments are made for you, you may be able to continue to coverage under the plan as long as the **policyholder** and we agree to do so and as described below: • Your coverage may continue until stopped by the **policyholder** but not beyond 24 months from the start of the absence.

It is your **policyholder's** responsibility to let us know when your employment ends. The limits above may be extended only if we and the **policyholder** agree in writing to extend them.

Special coverage options after your plan coverage ends is revised to change the title to **Special *coverage options after your coverage ends***.

All references to this section are revised accordingly. The section is revised as follows:

The following section in the **Consolidated Omnibus Budget Reconciliation Act (COBRA) Rights** section are deleted in their entirety and replaced:

How can you extend the length of your COBRA coverage? The chart below shows qualifying events after the start of COBRA (second qualifying events):

Qualifying event	Person affected (qualifying beneficiary)	Total length of continued coverage
You were disabled during the first 60 days of COBRA coverage (as determined by the Social Security Administration)	You and your dependents	29 months (18 months plus an additional 11 months)
• You die • 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 dependent under the plan	You and your dependents	Up to 36 months

How much will COBRA coverage cost?
For most COBRA qualifying events you and your dependents will pay 102% of the total plan costs. This additional 2% covers administrative fees. If you apply for COBRA because of a disability, the total due will change to 150% of the plan costs in your 19th month of COBRA.

Continuation of coverage for other reasons is revised to delete all of the following provisions:
How can you extend coverage when getting inpatient care when coverage ends?
How can you extend coverage for vision care services and supplies when coverage ends?
How can you extend coverage for a dependent after I die?

General provisions – other things you should know is revised as follows:

Intentional deception is deleted in its entirety and replaced with the following:
Intentional deception
If we learn that you defrauded us or you intentionally misrepresented material facts, we can take actions that can have serious effects on your coverage. These include, but are not limited to:

1. Loss of coverage, starting at the effective date of coverage.
2. Loss of coverage going forward.
3. Denial of benefits.
4. Recovery of amounts we already paid.

We also may report fraud to criminal authorities.

You have special rights if we rescind your coverage.

- We will give you 30 days advanced written notice of any rescission of coverage. The notice will:
  - Cleary 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 that you or your authorized representative, prior to the date the advance notice of the proposed rescission ends, may immediately file an internal appeal to request a reconsideration of the rescission
  - Describe the internal appeal process for rescissions, including any time limits
  - Include the date when date when the advance notice ends and provide the date back to which the coverage will be rescinded.
- We will promptly refund all premiums less any claims paid.

You have the right to an **Innovation Health** appeal. See **When you disagree - claim decisions and appeal procedures, Appeal of adverse benefit determination** for information on how to submit an appeal.

The ***Glossary*** is revised as follows:

The following definition is deleted:
Tier 1A - value drugs

The definition of **Detoxification** is revised to include services provided by nurse practitioners working within the scope of their license.

The following definitions are deleted in their entirety and replaced with new language:

Mental disorder
Mental disorders are defined in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). The DSM is a book published by the American Psychiatric Association. It describes all recognized **mental disorders**. In general, a **mental disorder** is a serious disturbance in a person's thought process, emotions or behavior that causes problems in mental functioning. **Mental disorders** are often connected to significant distress or disability in social, work or other important activities.

Negotiated charge
For health coverage, this is either:

- The amount a **network provider** has agreed to accept
- The amount we agree to pay directly to a **network provider** or third party vendor (including any administrative fee in the amount paid)

for providing services, **prescription drugs** or supplies to plan members. This does not include **prescription drug** services from a **network pharmacy**.

The **negotiated charge** does not reflect any amount an affiliate or we may receive under a rebate arrangement between us or an affiliate and a drug manufacturer for any **prescription drug**.

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

*For **prescription drug** services from a **network pharmacy**:*
The amount we established for each **prescription drug** obtained from a **network pharmacy** under this plan. This **negotiated charge** may reflect amounts we agreed to pay directly to the **network pharmacy** or to a third party vendor for the **prescription drug**, and may include an additional service or risk charge set by us.

The **negotiated charge** does not reflect any amount an affiliate or we may receive under a rebate arrangement between us, an affiliate or a third party vendor and a drug manufacturer for any **prescription drug**, including **prescription drugs** on the **drug guide**.

We may receive rebates from the manufacturers of **prescription drugs** and may receive or pay additional amounts from or to third parties under price guarantees. These amounts will not change the **negotiated charge** under this plan.

Network pharmacy
A **retail**, **mail order** or **specialty pharmacy** that has contracted with **us**, an affiliate, or a third party vendor, to provide outpatient **prescription drugs** to you. **Network pharmacies** include **out-of-network** pharmacies or its intermediary that have agreed by fax or otherwise to accept our payment as payment in full.

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

Recognized charge
The amount of an **out-of-network provider's** charge that is eligible for coverage. You are responsible for all amounts above what is eligible for coverage.

The **recognized charge** depends on the geographic area where you receive the service or supply. The table below shows the method for calculating the **recognized charge** for specific services or supplies:

Service or supply	**Recognized charge**
Professional services and other services or supplies not mentioned below	90% of the Medicare allowed rate
Services of **hospitals** and other facilities	90% of the Medicare allowed rate
Prescription drugs	50% of the average wholesale price (AWP)
Dental expenses	80% of the prevailing charge rate
Important note: if the **provider** bills less than the amount calculated using the method above, the **recognized charge** is what the **provider** bills.	

Recognized charge does not apply to involuntary services.

- Average wholesale price (AWP) is the current average wholesale price of a **prescription drug** listed in the Facts and Comparisons, Medi-span weekly price updates (or any other similar publication chosen by **Innovation Health**).
- Geographic area is normally based on the first three digits of the U.S. Postal Service zip codes. If we determine we need more data for a particular service or supply, we may base rates on a wider geographic area such as an entire state.
- Involuntary services are services or supplies that are one of the following:
  - Performed at a **network** facility by an **out-of-network provider,** unless that **out-of-network provider** is an assistant surgeon for your **surgery**
  - Not available from a **network provider**
  - **Emergency services**

  We will calculate your cost share for involuntary services in the same way as we would if you received the services from a **network provider**.
- Medicare allowed rates are the rates CMS establishes for services and supplies provided to Medicare enrollees. We update our systems with these revised rates within 180 days of receiving them from CMS. If Medicare does not have a rate, we use one or more of the items below to determine the rate:
  - The method CMS uses to set Medicare rates
  - What other **providers** charge or accept as payment
  - How much work it takes to perform a service
  - Other things as needed to decide what rate is reasonable for a particular service or supply

  Exceptions:
  - For inpatient services, the rate excludes amounts CMS allows for Operating Indirect Medical Education (IME) and Direct Graduate Medical Education (DGME).
  - Our rate also excludes other payments that CMS may make directly to **hospitals**. It also excludes any backdated adjustments made by CMS.
  - For anesthesia, the Medicare allowed rate is 105% of the general Medicare allowed rate.
  - For laboratory, the Medicare allowed rate is 75% lower than the general Medicare allowed rate.
  - For **DME**, the Medicare allowed rate is 75% lower than the general Medicare allowed rate.
  - For medications payable/covered as medical benefits rather than prescription drug benefits, our rate is 100% of the rates CMS establishes for those medications.
- Prevailing charge rate is the percentile value reported in a database prepared by FAIR Health, a nonprofit company. FAIR Health changes these rates periodically. We update our systems with these changes within 180 days after receiving them from FAIR Health. If the Fair Health database becomes unavailable, we have the right to substitute a different database that we believe is comparable.

Our reimbursement policies
We reserve the right to apply our reimbursement policies to all out-of-network services including involuntary services. Our reimbursement policies may affect the **recognized charge**. These policies consider:

- The duration and complexity of a service
- When multiple procedures are billed at the same time, whether additional overhead is required
- Whether an assistant surgeon is necessary for the service
- If follow up care is included
- Whether other characteristics modify or make a particular service unique
- When a charge includes more than one claim line, whether any services described by a claim line are part of, or related to, the primary service provided
- The educational level, licensure or length of training of the **provider**

Our reimbursement policies are based on our review of:

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

We use commercial software to administer some of these policies. The policies may be different for professional services and facility services.

Get the most value out of your benefits:
We have online tools to help decide whether to get care and, if so, where. Use the "Estimate the Cost of Care" tool on Navigator®. **Innovation Health's** secure member website at www.innovation-health.com may contain additional information that can help you determine the cost of a service or supply. Log on to Navigator® to access the "Estimate the Cost of Care" feature. Within this feature, view our "Cost of Care" and "Member Payment Estimator" tools.

Substance use disorder
This is a physical or psychological dependency, or both, on a controlled substance or alcohol agent. These are defined in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) published by the American Psychiatric Association. This term does not include conditions that you cannot attribute to a **mental disorder** that are a focus of attention or treatment or an addiction to nicotine products, food or caffeine intoxication.

Wellness and other incentives is deleted in its entirety and replaced with the following:

Wellness and other incentives

We may encourage and incent you to access certain medical services, to use online tools that enhance your coverage and services, and to continue participation as an **Innovation Health** member. You and your doctor can talk about these medical services and decide if they are right for you. We may also encourage and incent you in connection with participation and outcomes in a wellness or health improvement program. Incentives include but are not limited to:

- Modification to **copayment**, **deductible** or **coinsurance** amounts
- **Premium** discounts or rebates
- Contributions to health savings account
- Fitness center membership reimbursement
- Merchandise
- Coupons
- Gift cards
- Debit cards
- Any combination of the above

The award of any such incentive shall not depend upon the result of a wellness or health improvement activity or upon a member's health status.

This amendment makes no other changes to the Group Policy or the Booklet-Certificate.

David Notari
Chief Executive Officer

Innovation Health Insurance Company

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.

Additional Information Provided by Your Employer

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

Note: This sub-section applies to the Plan if your Employer employs 20 or more employees in accordance with a formula mandated by federal law. Check with your Employer to determine if COBRA continuation applies to the Plan.

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.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to preexisting condition exclusion for 12 months after your enrollment date in your coverage under this Plan. Contact your Plan Administrator for assistance in obtaining a certificate of creditable coverage.

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, http://www.dol.gov/ebsa/consumer_info_health.html.

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.

Important Information about the Affordable Care Act (ACA)

Non-discrimination Rule

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

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

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

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

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

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

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

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

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

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

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates. Aetna companies that receive funds from the federal Department of Health and Human Services are subject to the Rule.

Important Information About Your Plan

Coverage of Applied Behavior Analysis
For the Treatment of Autism Spectrum Disorder

Your Plan includes coverage for the diagnosis and treatment of autism spectrum disorder. Eligible health services include the services and supplies provided by a physician or behavioral health provider for the diagnosis and treatment of autism spectrum disorder.

As part of this coverage, we will cover certain early intensive behavioral interventions, such as applied behavior analysis. Applied behavior analysis is an educational service that is the process of applying interventions:

- That systematically change behavior, and
- That are responsible for observable improvements in behavior.

Applied behavioral analysis will be subject to the same cost sharing requirements as other, outpatient services provided by a behavioral health provider for the treatment of autism spectrum disorder.

Important notes:

For plans that did not include such coverage previously, applied behavior analysis for the treatment of autism spectrum disorder will be an eligible health service for all new and renewing policies or plans with an effective date on or after January 1, 2017.

Applied behavior analysis requires precertification by Aetna.

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

Note: This sub-section applies to the Plan if your Employer employs 50 or more employees as determined by a formula defined by federal law. Check with your Employer to determine if FMLA applies to the Plan.

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

Preferred Provider Organization (PPO)
Medical Plan

Schedule of benefits

If this is an ERISA plan, you have certain rights under this plan. If the policyholder is a church group or a government group, this may not apply. Please contact the policyholder for additional information.

Underwritten by Innovation Health Insurance Company in the Commonwealth of Virginia

Schedule of benefits

This schedule of benefits lists the **deductibles**, **copayments** or **coinsurance**, if any that apply to the **eligible health services** you get under this plan. You should read this schedule to become aware of these and any limits that apply to the services.

How to read your schedule of benefits

- You must pay any **deductibles**, **copayments** or **coinsurance**, if they apply.
- You must pay the full amount of any health care service you get that is not an **eligible health service**.
- This plan has limits for some **covered benefits**. For example, these could be visit, day or dollar limits. They may be:
  - combined limits between
  - separate limits for

in-network **providers** and **out-of-network providers** unless we say differently.

Important note:
All **covered benefits** are subject to the **plan year deductible**, **out-of-pocket maximum**, limits, **copayment** or **coinsurance** unless otherwise noted in this schedule of benefits below.

How your deductible works

This schedule of benefits shows the **deductible** amounts that apply to your plan. Once you have met your **deductible**, we will start sharing the cost when you get **eligible health services**. You will continue to pay **copayments** or **coinsurance**, if any, for **eligible health 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 receive **eligible health services** from any **PCP**.

How your maximum out-of-pocket limit works

This schedule of benefits 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 **eligible health services** for the remainder of that year.

How to contact us for help

We are here to answer your questions.

- Log onto your Navigator® secure member website at www.innovation-health.com
- Call the phone number on your ID card

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 booklet-certificate.

Plan features	Deductible/maximums	
	In-network coverage	**Out-of-network coverage**
Deductible		
You have to meet your **deductible** before this plan pays for **eligible health services**.		
Individual	$1,000 per year	$5,000 per year
Family	$2,000 per year	$10,000 per year
Deductible waiver		
The in-network **deductible** is waived for all of the following **eligible health services**: • Preventive care and wellness • Nutritional support • Family planning services - female contraceptives The out-of-network **deductible** is waived for all of the following **eligible health services**: • Well woman preventive visits • Well baby/child preventive visits including immunizations • Nutritional support		

Maximum out-of-pocket limit		
Individual	$7,350 per year	Unlimited per year
Family	$14,700 per year	Unlimited per year
Precertification covered benefit reduction		
Your booklet-certificate contains a complete description of the pre-approval program. You will find details on pre-approval in the *Medical necessity and precertification requirements* section. If you don't get pre-approval of your **eligible health services** when required, this plan will reduce by 50% up to $400 what we will pay for each type of **eligible health service**. You may have to pay the additional amount of the **recognized charge** because you didn't get pre-approval. This amount is not a **covered benefit** and does not apply to your **deductible** or your **maximum out-of-pocket limit**, if any.		

General coverage provisions

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

Deductible provisions
Eligible health services applied to the in-network **deductible** apply only to the in-network **deductible**. **Eligible health services** applied to the out-of-network **deductible** apply only to the out-of-network **deductible**.
The **deductible** may not apply to certain **eligible health services**. You must pay any applicable cost share for **eligible health services** to which the **deductible** does not apply.
Individual **deductible** You pay for **eligible health services** each year before the plan begins to pay. This individual **deductible** applies separately to you and each covered dependent. Once you have reached the **deductible**, this plan will begin to pay for **eligible health services** for the rest of the year.
Family **deductible** You pay for network **eligible health services** each year before the plan begins to pay. After the amount paid for **eligible health services** reaches your family **deductible**, this plan will begin to pay for **eligible health services** for the rest of the year.

To satisfy this family **deductible** for the rest of the year, the combined **eligible health services** that you and each of your covered dependents incur towards 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.

Maximum out-of-pocket limits provisions

Eligible health services that are subject to the **maximum out-of-pocket limit** may include **covered benefits** provided under the medical plan and the outpatient **prescription drug** plan.

Eligible health services applied to the in-network **maximum out-of-pocket limit** apply only to the in-network **maximum out-of-pocket limit**. **Eligible health services** applied to the out-of-network **maximum out-of-pocket limit** apply only to the out-of-network **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.

Individual **maximum out-of-pocket limit**
Once you or your covered dependents meet the individual **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered benefits** that apply toward the limit for the rest of the year for that person.

Family **maximum out-of-pocket limit**
Once you or your covered dependents meet the family **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered benefits** that apply toward the limit for the remainder of the year for all covered family members.

To satisfy this family **maximum out-of-pocket limit** for the rest of the year, the following must happen:

- The family **maximum out-of-pocket limit** is a cumulative **maximum out-of-pocket limit** for all family members
- 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 benefit**, your cost share for that **covered benefit** will not count toward satisfying the **maximum out-of-pocket limit** amount.

Certain costs that you incur do not apply toward the **maximum out-of-pocket limit**. These include:

- All costs for non-covered services
- Any out of pocket costs for non-emergency use of the emergency room
- Any out of pocket costs incurred for non-urgent use of an **urgent care provider**

Limit provisions

Eligible health services will apply to the in-network limit and the out-of-network limit.

Your financial responsibility and decisions regarding benefits

We base your financial responsibility for the cost of services on when the service or supply is provided, not when payment is made. 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 booklet-certificate.

Eligible health services	In-network coverage	Out-of-network coverage
1. Preventive care and wellness		
Preventive care and wellness	0%, no **deductible** applies	50% after **deductible**
• **Routine physical exams -** Performed at a **physician** office • **Preventive care immunizations -** Performed at a facility or at a **physician** office • **Well woman preventive visits - routine gynecological exams (including pap smears) -** Performed at a **physician**, obstetrician (OB), gynecologist (GYN) or OB/GYN office • **Preventive screening and counseling services -** Includes obesity and/or healthy diet counseling, misuse of alcohol and/or drugs, use of tobacco products, sexually transmitted infection counseling, genetic risk counseling for breast and ovarian cancer - Office visits • **Routine cancer screenings -** Applies whether performed at a **physician**, **specialist** office or facility • **Prenatal care services -** Provided by an obstetrician (OB), gynecologist (GYN), and/or OB/GYN • **Comprehensive lactation support and counseling services -** Facility or office visits • **Breast feeding durable medical equipment -** Breast pump supplies and accessories • **Family planning services -** Female contraceptive counseling services office visit, devices, voluntary sterilization		
Preventive care and wellness benefit limitations		
Routine physical exams: • 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 guidelines for children and adolescents. • Limited to 7 exams from age 0 - 12 months, 3 exams age 1-2, 3 exams age 2-3 and 1 exam every 12 months after that 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 one every 36 months		
Preventive care immunizations: Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician.**		
Well woman preventive visits - routine gynecological exams (including pap smears): Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.		
Preventive screening and counseling services: Limitations are per 12 months unless stated below:		
Obesity and/or healthy diet	Unlimited visits from age 0-22, 26 visits every 12 months age 22 or older, of which up to 10 visits may be used for healthy diet counseling	
Misuse of alcohol and/or drugs	Limited to 5 visits every 12 months	
Use of tobacco products	Limited to 8 visits every 12 months	
Sexually transmitted infection	Limited to 2 visits every 12 months	
Genetic risk counseling for breast and ovarian cancer	Not subject to any age or frequency limitations	

Routine cancer screenings:

Subject to any age; family history; and frequency guidelines as set forth in the most current:

- 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
- The comprehensive guidelines supported by the Health Resources and Services Administration

Lung cancer screenings that exceed the cancer-screening limit are covered under the *Outpatient diagnostic testing* section.

Prenatal care services: Review the *Maternity and related newborn care* section of your booklet-certificate. It will give you more information on coverage levels for maternity care under this plan.

Comprehensive lactation support and counseling services:

- Lactation counseling services limited to 6 visits per 12 months either in a group or individual setting
- Any visits that exceed the lactation counseling services maximum are covered under **physician** services office visits

Breast feeding durable medical equipment: See the *Breast feeding durable medical equipment* section of the booklet-certificate for limitations on breast pump and supplies.

Family planning services:

- Contraceptive counseling services limited to 2 visits per 12 months in either a group or individual setting

Eligible health services	In-network coverage	Out-of-network coverage
2. Physicians and other health professionals		
Physician services		
Office hours visits (non-surgical) non preventive care	$30 **copay,** no **deductible** applies	50% after **deductible**
Telemedicine consultation by a **physician** or **PCP**	Covered based on type of service and where it is received	50% after **deductible**
Visit limit per day	None	
Specialist office visits		
Office hours visit (non-surgical)	$75 **copay,** no **deductible** applies	50% after **deductible**
Telemedicine		
Telemedicine consultation by a **specialist**	Covered based on type of service and where it is received	50% after **deductible**
Visit limit per day	None	
Allergy injections		
Without a **physician** or **specialist** office visit	0% after **deductible**	50% after **deductible**
Allergy testing and treatment		
Performed at a **physician** or **specialist** office	Covered based on type of service and where it is received	50% after **deductible**
Immunizations when not part of the physical exam		
Immunizations when not part of the physical exam	Covered based on the type of service and where it is received	Covered based on the type of service and where it is received
Medical injectables		
Performed at a **physician** or **specialist** office	0% after **deductible**	50% after **deductible**
Physician surgical services		
Inpatient surgical services	0% after **deductible**	50% after **deductible**
Performed at a **physician** or **specialist** office	Covered based on type of service and where it is received	50% after **deductible**

Alternatives to physician office visits		
Walk-in clinic visits		
Walk-in clinic non-emergency visit	$30 **copay,** no **deductible** applies	50% after **deductible**
Preventive care immunizations	0%, no **deductible** applies	0%, no **deductible** applies
Individual screening and counseling services at a walk-in clinic Includes obesity and/or healthy diet counseling, use of tobacco products		
Individual screening and counseling services	0%, no **deductible** applies	50% after **deductible**
Limitations: • Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention • For details, contact your **physician** • Refer to the *Preventive care and wellness section* earlier in this schedule of benefits for limits that may apply to these types of services		
Important note: Not all preventive care services are available at **walk-in clinics**. The types of services offered will vary by the **provider** and location of the clinic. These services may also be obtained from a network **physician**.		

Eligible health services	In-network coverage	Out-of-network coverage
3. Hospital and other facility care		
Hospital care		
Inpatient **hospital**	0% after **deductible**	50% after **deductible**
Alternatives to hospital stays		
Outpatient surgery		
Performed in **hospital** outpatient department	$10 **copay** after **deductible**	50% after **deductible**
Performed in facility other than **hospital** outpatient department	$10 **copay** after **deductible**	50% after **deductible**
Physician services	$0 after **deductible**	50% after **deductible**
Home health care		
Outpatient	0% after **deductible**	50% after **deductible**
Visit limit per year	Coverage is limited to 100 visits per **plan** year network and out-of-network combined	
Hospice care		
Inpatient services	0% after **deductible**	50% after **deductible**
Outpatient services	0% after **deductible**	50% after **deductible**
Skilled nursing facility		
Inpatient facility	0% after **deductible**	50% after **deductible**
Day limit	Coverage is limited to 100 days per admission network and out-of-network combined	
Private duty nursing		
Outpatient private duty nursing	50% after **deductible**	
Limit per year	Coverage is limited to 16 hours per **plan** year network and out-of-network combined	

Eligible health services	In-network coverage	Out-of-network coverage
4. Emergency services and urgent care A separate **hospital** emergency room or urgent care cost share will apply for each visit to an emergency room or an **urgent care provider**.		
Hospital emergency room (Includes initial screening and stabilization)	$500 **copay,** no **deductible** applies	Paid the same as in-network coverage
Non-emergency care in a **hospital** emergency room	Not covered	Not covered
Important note: • **Out-of-network providers** do not have a contract with us. The **provider** may not accept payment of your cost share (**deductible**, **copayment**, **coinsurance**), as payment in full. You may receive a bill for the difference between the amount billed by the **provider** and the amount paid by this plan. If the **provider** bills you for an amount above your cost share, you are not responsible for paying that amount under this policy. • You should send the bill to the address listed on the back of your ID card, and we will resolve any payment dispute with the **provider** over that amount. Make sure the member's ID number is on the bill. • If you are admitted to a **hospital** as an inpatient right after a visit to an emergency room, your emergency room **copay** will be waived.		
Urgent medical care at a free standing facility that is not a **hospital**	$75 **copay,** no **deductible** applies	50% after **deductible**
Non-urgent use of **urgent care provider** at a free standing facility that is not a **hospital**	Not covered	Not covered

Eligible health services	In-network coverage	Out-of-network coverage
5. Pediatric dental care		
Coverage is limited to covered persons through the end of the month in which the person turns 19		
Type A services	0% after **deductible**	30% after **deductible**
Type B services	30% after **deductible**	50% after **deductible**
Type C services	50% after **deductible**	50% after **deductible**
Orthodontic services	50% after **deductible**	50% after **deductible**
Dental benefits are subject to the plan's **deductible** and **maximum out-of-pocket limit**, if any and as explained in this schedule of benefits.		

Diagnostic and preventive care (type A services)

Visits and images

- Office visit during regular office hours for oral examination - limited to 2 visits every 12 months beginning with the eruption of the first tooth
- Routine comprehensive or recall examination - limited to 2 visits every 12 months beginning with the eruption of the first tooth
- Problem-focused examination - limited to 2 visits every 12 months
- Prophylaxis (cleaning) - limited to 2 treatments per year
- Topical application of fluoride - limited to 2 courses of treatment per year
- Sealants - limited to 1 application every 3 years per tooth for permanent molars only
- Bitewing images/x-rays
- Periapical images/x-rays - single films up to 16
- Complete image series including bitewings if **medically necessary** or panoramic radiographic image - limited to 1 set every 3 years
- Vertical bitewing images/x-rays - limited to 1 set every 3 rolling years
- Cephalometric radiographic image
- Intra-oral, occlusal radiographic image
- Diagnostic casts

Space maintainers

Includes all adjustments within 6 months after installation.

- Fixed (unilateral or bilateral)
- Removable (unilateral or bilateral)
- Re-cementation of space maintainer
- Removal of space maintainer by other than the dentist or office that placed it

Basic restorative care (type B services)

Visits and images

- Professional visit after hours - payment will be made on the basis of services rendered or visit, whichever is greater
- Emergency palliative treatment, per visit

- Consultation by other than the treating provider
- Hospital call

Other Expenses

- Therapeutic drug injections
- Therapeutic parental drugs
- Application of desensitive medication

Images and pathology

- Extra-oral posterior dental radiographic image
- Biopsy and accession of tissue examination of oral tissue

Oral surgery

- Extractions
  - Erupted tooth or exposed root
  - Coronal remnants
  - Surgical removal of erupted tooth/root tip
- Impacted teeth
  - Removal of tooth (soft tissue)
- Odontogenic cysts
  - Removal of odontogenic cyst or tumor
- Other Surgical Procedures
  - Alveoplasty in conjunction with extractions - per quadrant
  - Alveoplasty in conjunction with extractions, 1 to 3 teeth or tooth spaces - per quadrant
  - Alveoplasty not in conjunction with extraction - per quadrant
  - Alveoplasty not in conjunction with extractions, 1 to 3 teeth or tooth spaces - per quadrant
  - Excision of hyperplastic tissue
  - Removal of exostosis
  - Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
  - Transplantation of tooth or tooth bud (Includes reimplantation from one site to another and splinting and/or stabilization)
  - Closure of oral fistula of maxillary sinus
  - Crown exposure to aid eruption
  - Incision and drainage of abscess, soft tissue
  - Frenulectomy/frenuloplasty

Periodontics

- Occlusal adjustment other than with an appliance or by restoration
- Root planing and periodontal scaling, 4 or more teeth per quadrant - limited to 4 separate quadrants every 2 years
- Root planing and periodontal scaling (1 to 3 teeth per quadrant) - limited to 4 separate quadrants every 2 years
- Gingivectomy /gingivoplasty per quadrant - limited to 1 per quadrant every 2 years
- Gingivectomy /gingivoplasty (1 to 3 teeth per quadrant) - limited to 1 per site every 2 years

- Gingival flap procedure per quadrant - limited to 1 per quadrant every 2 years
- Gingival flap procedure (1 to 3 teeth per quadrant) - limited to 1 per site every 2 years
- Provisional splinting
- Periodontal maintenance procedures following active therapy - 4 in 12 months combined with adult prophylaxis after the completion of active periodontal therapy
- Localized delivery of antimicrobial agents

Endodontics

- Pulp capping, direct and indirect
- Pulpotomy
- Pulp debridement
- Pulpal therapy anterior and posterior primary tooth
- Apexification/pulpal regeneration
- Apexification/recalcification
- Apicoectomy/periadicular surgery anterior, bicuspid, molar
- Retrograde filing
- Root canal therapy including images/x-rays:
  - Anterior
  - Bicuspid
- Retreatment of previous root canal therapy:
  - Anterior
  - Bicuspid
- Root amputation
- Hemisection including any root removal

Restorative dentistry

Excludes inlays, crowns other than prefabricated stainless steel or resin and bridges.
Multiple restorations in 1 surface will be considered as a single restoration

- Amalgam restorations
- Resin-based composite restorations other than for molars
- Pin retention per tooth in addition to amalgam or resin restoration
- Crowns when tooth cannot be restored with a filling material
  - Prefabricated stainless steel
  - Prefabricated resin crown excluding temporary crowns
  - Protective Restoration
- Re-cementation
  - Inlay
  - Crown
  - Bridge

Major restorative care (type C services)

Oral Surgery

- Surgical removal of impacted teeth
  - Removal of partially bony tooth
  - Removal of completely bony tooth

Periodontics

- Osseous surgery including flap and closure, 1 to 3 teeth per quadrant - limited to 1 per site every 3 years
- Osseous surgery including flap and closure, 4 or more teeth per quadrant - limited to 1 per quadrant every 3 years
- Pedical soft tissue graft procedures
- Bone replacement graft
- Autogenous connective tissue graft procedures
- Free soft tissue graft
- Full Mouth Debridement -limited to 1 every 12 months

Endodontics

- Molar root canal therapy(endodontic therapy), including **medically necessary** images/x-rays
- Retreatment of previous molar root canal therapy

Restorative

Inlays, onlays, labial veneers and crowns are covered only as treatment for decay or acute traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge. The following services are limited to 1 per tooth every 5 years per service:

- Inlays/onlays
- Crowns
  - Resin
  - Resin with high noble metal
  - Resin with noble metal
  - Resin with base metal
  - Porcelain/ceramic substrate
  - Porcelain fused to high noble metal
  - Porcelain fused to noble metal
  - Porcelain fused to base metal
  - Base metal (full cast)
  - Noble metal (full cast)
  - 3/4 cast metallic or porcelain/ceramic
  - Titanium
  - Provisional crown
  - Retainer crowns

- Post and core
- Core build-up
- Temporary crown

Prosthodontics

- Replacement of existing bridges or dentures- limited to 1 every 5 years
- Bridge abutments (See inlays/onlays and crowns) - limited to 1 every 5 years
- Pontics
  - Base metal (full cast) – limited to 1 per tooth every 5 years
  - Noble metal (full cast) – limited to 1 per tooth every 5 years
  - Porcelain with noble metal - limited to 1 per tooth 1 every 5 years
  - Porcelain with base metal - limited to 1 per tooth 1 every 5 years
  - Resin with noble metal - limited to 1 per tooth 1 every 5 years
  - Resin with base metal - limited to 1 per tooth 1 every 5 years
  - Titanium – limited to 1 per tooth every 5 years
- Removable bridge (unilateral) – limited to 1 per tooth every 5 years
- One piece casting, chrome cobalt alloy clasp attachment (all types) per unit including pontics – limited to 1 every 5 years
- Dentures and partials (Fees for dentures and partial dentures include relines, rebases and adjustments within 6 months after installation. Fees for relines and rebases include adjustments within 6 months after installation. Specialized techniques and characterizations are not eligible.)
- Complete upper denture – limited to 1 every 5 years per service
- Complete lower denture – limited to 1 every 5 years per service
- Immediate upper denture / Immediate upper partial denture – limited to 1 every 5 years per service
- Immediate lower denture / Immediate lower partial denture – limited to 1 every 5 years per service
- Partial upper or lower resin base- including any conventional clasps, rests and teeth – limited to 1 every 5 years per service
- Partial upper or lower cast metal base with resin saddles- including any conventional clasps, rests and teeth – limited to 1 every 5 years per service
- Stress breakers
- Interim partial denture (stayplate), anterior only
- Office reline
- Laboratory reline
- Special tissue conditioning per denture
- Rebase, per denture
- Adjustment to denture more than 6 months after installation
- Full and partial denture repairs
  - Broken dentures, no teeth involved
  - Repair cast framework
- Broken dentures with no teeth involved
- Repair cast framework
- Replacing missing or broken teeth, each tooth
- Adding teeth to existing partial denture
  - Each tooth
  - Each clasp

- Repairs: crowns and bridges
- Occlusal guard, for bruxism only
- Occlusal guard adjustment (Not eligible within first 6 months after placement of appliance)
- Occlusal orthotic device- limited to jaw joint disorder
- Fixed and removable appliance therapy (includes appliances for thumb sucking and tongue thrusting)
- Feeding aid

General anesthesia and intravenous sedation

- Only when **medically necessary** and provided in conjunction with a covered dental surgical procedure
- Non-intravenous conscious sedation only when medically necessary and only when provided in conjunction with a covered dental surgical procedure
- Nitrous oxide/analgesia
- Other drug and/or medicaments
- Behavior management only when **medically necessary**

Local Anesthesia

- The fee for local anesthesia is included in the operative or surgical treatment procedure

Orthodontic services

- Medically necessary orthodontic treatment
- Replacement of retainer, limited to 1 per lifetime

Eligible health services	In-network coverage	Out-of-network coverage
6. Specific conditions		
Autism spectrum disorder		
Autism spectrum disorder	Covered based on the type of service and where it is received	Covered based on the type of service and where it is received
Applied behavior analysis	$75 **copay,** no **deductible** applies	50% after **deductible**
Diabetic equipment, supplies and education		
Diabetic equipment	Covered based on the type of service and where it is received	Covered based on the type of service and where it is received
Diabetic supplies	Covered based on the type of service and where it is received	Covered based on the type of service and where it is received
Diabetic education	Covered based on the type of service and where it is received	Covered based on the type of service and where it is received
Family planning services - other		
Inpatient services		
Voluntary sterilization for males	0% after **deductible**	50% after **deductible**
Abortion (termination of pregnancy)	0% after **deductible**	50% after **deductible**
Outpatient services		
Voluntary sterilization for males	Covered based on type of service and where it is received	50% after **deductible**
Abortion (termination of pregnancy)	Covered based on type of service and where it is received	50% after **deductible**
Jaw joint disorder treatment		
Jaw joint disorder treatment	0% after **deductible**	50% after **deductible**
Maternity and related newborn care		
Prenatal care services		
Inpatient and other maternity related services and supplies	0% after **deductible**	50% after **deductible**
Other prenatal care services and supplies	Covered based on the type of service and where it is received	Covered based on the type of service and where it is received
Delivery services and postpartum care services		
Inpatient and newborn care services and supplies	0% after **deductible**	50% after **deductible**
Performed in a facility or at a **physician** office	0% after **deductible**	50% after **deductible**
Important note: Any cost share that is collected applies to the delivery and postpartum care services provided by an OB, GYN, or OB/GYN only. This cost share does not apply to prenatal care services provided by an OB, GYN, or OB/GYN.		

Mental health treatment Coverage provided under the same terms, conditions as any other **illness**.		
Inpatient mental health treatment Inpatient **residential treatment facility**	0% after **deductible**	50% after **deductible**
Other inpatient mental health treatment services and supplies Other inpatient **residential treatment facility** services and supplies	0% after **deductible**	50% after **deductible**
Outpatient mental health treatment visits to a **physician** or **behavioral health provider** (includes **telemedicine**)	$75 **copay,** no **deductible** applies	50% after **deductible**
Other outpatient mental health treatment or skilled behavioral health services in the home, **partial hospitalization treatment** and **intensive outpatient program**	$75 **copay,** no **deductible** applies	50% after **deductible**
Substance use disorder treatment Coverage provided under the same terms, conditions as any other **illness**.		
Inpatient **substance use disorder detoxification** Inpatient **substance use disorder** rehabilitation Inpatient **substance use disorder** treatment in **residential treatment facility**	0% after **deductible**	50% after **deductible**
Other inpatient **substance use disorder detoxification** services and supplies Other inpatient **substance use disorder** rehabilitation services and supplies Other inpatient **substance use disorder residential treatment facility** services and supplies	0% after **deductible**	50% after **deductible**
Outpatient **substance use disorder** visits to a **physician** or **behavioral health provider** (includes **telemedicine**)	$75 **copay,** no **deductible** applies	50% after **deductible**

Other outpatient **substance use disorder** services or **partial hospitalization treatment** and **intensive outpatient program**	$75 **copay,** no **deductible** applies	50% after **deductible**
Important note: • **Partial hospitalization treatment** is at least 6 hours, but less than 24 hours per day of clinical treatment provided in a facility or program for treatment of **substance use disorder**. Treatment is provided under the direction of a **physician**. • **Intensive outpatient program** is at least 3 hours per day and at least 6 hours per week of clinical treatment provided in a facility or program for treatment of **substance use disorder**. Treatment is provided under the direction of a **physician**.		
Reconstructive breast surgery		
Reconstructive breast **surgery**	Covered based on the type of service and where it is received	Covered based on the type of service and where it is received
Reconstructive surgery and supplies		
Reconstructive **surgery** and supplies	Covered based on the type of service and where it is received	Covered based on the type of service and where it is received

Eligible health services	Network (IOE facility)	Network (Non-IOE facility) and out-of-network coverage
Transplant services		
Inpatient and other inpatient services and supplies	0% after **deductible**	50% after **deductible**
Outpatient	Coverage limited to IOE only	50% after **deductible**
Physician services	Coverage limited to IOE only	50% after **deductible**

Eligible health services	In-network coverage	Out-of-network coverage
Treatment of basic infertility		
Basic **infertility**	Covered based on the type of service and where it is received	Covered based on the type of service and where it is received

Eligible health services	In-network coverage	Out-of-network coverage
7. Specific therapies and tests		
Outpatient diagnostic testing		
Diagnostic complex imaging services		
Performed at a facility	$350 **copay,** no **deductible** applies	50% after **deductible**
Performed at **physician** office	Included in office visit **copay**	50% after **deductible**
Performed at **specialist** office	Included in office visit **copay**	50% after **deductible**
Diagnostic lab work		
Performed at a facility	$75 **copay,** no **deductible** applies	50% after **deductible**
Performed at **physician** office	Included in office visit **copay**	50% after **deductible**
Performed at **specialist** office	Included in office visit **copay**	50% after **deductible**
Diagnostic radiological services (X-ray)		
Performed at a facility	$75 **copay,** no **deductible** applies	50% after **deductible**
Performed at **physician** office	Included in office visit **copay**	50% after **deductible**
Performed at **specialist** office	Included in office visit **copay**	50% after **deductible**
Outpatient therapies		
Chemotherapy		
Chemotherapy	Covered based on the type of service and where it is received	Covered based on the type of service and where it is received
Outpatient infusion therapy		
Performed in a **physician** office or in a person's home	$75 **copay,** no **deductible** applies	50% after **deductible**
Performed in outpatient facility	0% after **deductible**	50% after **deductible**
Radiation therapy		
Radiation therapy	Covered based on the type of service and where it is received	Covered based on the type of service and where it is received
Specialty prescription drugs		
Performed in a **physician** office Performed in the outpatient department of a **hospital** Performed in an outpatient facility that is not a **hospital** or in the home	Covered based on the type of service and where it is received	Covered based on the type of service and where it is received
Cardiac and pulmonary rehabilitation services A visit is equal to no more than 1 hour of therapy.		
Cardiac and pulmonary rehabilitation	$75 **copay,** no **deductible** applies	50% after **deductible**
Rehabilitation therapy services A visit is equal to no more than 1 hour of therapy.		

Outpatient physical therapy		
Physical therapy (PT)	$75 **copay,** no **deductible** applies	50% after **deductible**
Visit limit per year	Coverage is limited to 30 visits per **plan** year PT/OT combined, rehabilitation & habilitation separate network and out-of-network combined	
Outpatient occupational therapy		
Occupational therapy (OT)	$75 **copay,** no **deductible** applies	50% after **deductible**
Visit limit per year	Coverage is limited to 30 visits per **plan** year PT/OT combined, rehabilitation & habilitation separate network and out-of-network combined	
Outpatient speech therapy		
Speech therapy	$75 **copay,** no **deductible** applies	50% after **deductible**
Visit limit per year	Coverage is limited to 30 visits per **plan** year, rehabilitation & habilitation separate network and out-of-network combined	
Habilitation therapy services A visit is equal to no more than 1 hour of therapy.		
Physical, occupational, and speech therapies	$75 **copay,** no **deductible** applies	50% after **deductible**
Visit limit per year	Coverage is limited to 30 visits per **plan** year PT/OT combined and 30 visits per **plan** year speech therapy, rehabilitation & habilitation separate network and out-of-network combined	
Early intervention services		
Early intervention services for children from birth up to age 3	$75 **copay,** no **deductible** applies	50% after **deductible**
Visit limit per year	None	

Eligible health services	In-network coverage	Out-of-network coverage
8. Other services		
Acupuncture		
Acupuncture	Not covered	Not covered
Ambulance service		
Emergency **ambulance**	0% after **deductible**	Covered same as in-network
Non-emergency **ambulance**	0% after **deductible**	Covered same as in-network
Clinical trial therapies (experimental or investigational)		
Clinical trial therapies (including routine patient costs)	Covered based on the type of service and where it is received	Covered based on the type of service and where it is received
Durable medical equipment (DME)		
DME	50% after **deductible**	50% after **deductible**
Limit per year	None	
Nutritional support		
Nutritional support	0%, no **deductible** applies	50%, no **deductible** applies
Prosthetic devices		
Prosthetic devices	30% after **deductible**	50% after **deductible**
Spinal manipulation		
Spinal manipulation	25% after **deductible**	25% after **deductible**
Visit limit per year	Coverage is limited to 30 visits per **plan** year for rehabilitation **services** and 30 visits per **plan** year for habilitation **services** network and out-of-network combined	
Vision care		
Pediatric vision care **Coverage is limited to covered persons through the end of the month in which the person turns 19**		
Routine vision exams (including refraction)		
Performed by an ophthalmologist or optometrist	50% after **deductible**	50% after **deductible**
Visit limit	Coverage is limited to 1 exam every 12 months age 0-19 network and out-of-network combined	
Vision care services and supplies		
Office visit for fitting of contact lenses	Not covered	Not covered
Eyeglass frames, **prescription** lenses or **prescription** contact lenses	50% after **deductible**	Not covered
Number of eyeglass frames per year	One set of eyeglass frames	
Number of **prescription** lenses per year	One pair of **prescription** lenses	
Number of **prescription** contact lenses per year	Daily disposables: up to 3 month supply Extended wear disposable: up to 6 month supply Non-disposable lenses: one set	

Adult vision care: Limited to covered person age 19 and over		
Routine vision exams (including refraction)		
Performed by an ophthalmologist or optometrist	50% after **deductible**	Not covered
Visit limit	Coverage is limited to 1 exam every 12 months network and out-of-network combined	

9. Outpatient prescription drugs

Waiver for risk reducing breast cancer prescription drugs

The **prescription drug** 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%.

Waiver for contraceptives

The **prescription drug** cost share will not apply to female contraceptive methods when obtained at a **network pharmacy**. This means they will be paid at 100% for:

- The following female contraceptives that are **generic prescription drugs**:
  - Oral drugs
  - Injectable drugs
  - Vaginal rings
  - Transdermal contraceptive patches
- Female contraceptive devices that are generic and brand-name devices
- FDA approved female:
  - Generic emergency contraceptives
  - Generic over-the-counter (OTC) emergency contraceptives

The **prescription drug** cost share will apply to **prescription drugs** that have a generic equivalent or biosimilar or generic alternative available within the same therapeutic drug class obtained at a **network pharmacy** unless you receive a medical exception. To the extent **generic prescription drugs** are not available, **brand-name prescription** drugs are covered. 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**.

Waiver for tobacco cessation prescription and over-the-counter drugs

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

Eligible health services	In-network coverage	Out-of-network coverage
Per prescription cost share		
Tier 1 - preferred generic prescription drugs		
For each 30 day supply filled at a **retail pharmacy**	$10 **copay**	50% **coinsurance**
For all fills greater than a 30 day supply but no more than a 90 day supply filled at a **retail or mail order pharmacy**	$25 **copay**	Not covered
Tier 2 - preferred brand-name prescription drugs		
For each 30 day supply filled at a **retail pharmacy**	$45 **copay**	50% **coinsurance**
For all fills greater than a 30 day supply but no more than a 90 day supply filled at a **retail or mail order pharmacy**	$112.50 **copay**	Not covered
Tier 3 - non-preferred generic and brand-name prescription drugs		
For each 30 day supply filled at a **retail pharmacy**	$85 **copay**	50% **coinsurance**
For all fills greater than a 30 day supply but no more than a 90 day supply filled at a **retail or mail order pharmacy**	$212.50 **copay**	Not covered
Important note: Tier 1, 2 and 3 **specialty prescription drugs** are not eligible for fill at a **retail pharmacy** or **mail order pharmacy**.		
Tier 4 - preferred specialty prescription drugs (including biosimilar prescription drugs)		
For each 30 day supply filled at a specialty **network pharmacy**	30% up to $300 per **prescription**	Not covered
Tier 5 - non-preferred specialty prescription drugs (including biosimilar prescription drugs)		
For each 30 day supply filled at a specialty **network pharmacy**	40% up to $500 per **prescription**	Not covered
Diabetic supplies and insulin		
For each 30 day supply filled at a **retail pharmacy**	Paid according to the tier of drug in the schedule of benefits, above	Paid according to the tier of drug in the schedule of benefits, above
For all fills greater than a 30 day supply but no more than a 90 day supply filled at a **retail** or **mail order pharmacy**	Paid according to the tier of drug in the schedule of benefits, above	Paid according to the tier of drug in the schedule of benefits, above

Orally administered anti-cancer medications		
For each 30 day supply filled at a specialty **network pharmacy**	Paid according to the tier of drug in the schedule of benefits, above	Paid according to the tier of drug in the schedule of benefits, above
Outpatient prescription contraceptive drugs and devices: includes oral and injectable drugs, vaginal rings and transdermal contraceptive patches		
Female contraceptives that are **generic prescription drugs**. For each 30 day supply.	$0 per **prescription** or refill	50% **coinsurance**
Female contraceptives that are **brand-name prescription drugs**. For each 30 day supply.	Paid according to the tier of drug in the schedule of benefits, above	Paid according to the tier of drug in the schedule of benefits, above
Important note: Brand-name vaginal rings covered at 100% to the extent that a generic is not available.		
Female contraceptive generic devices and brand-name devices. For each 30 day supply.	Paid according to the tier of drug in the schedule of benefits, above	Paid according to the tier of drug in the schedule of benefits, above
FDA-approved female generic and brand-name emergency contraceptives. For each 30 day supply.	Paid according to the tier of drug in the schedule of benefits, above	Paid according to the tier of drug in the schedule of benefits, above
FDA-approved female generic and brand-name over-the-counter emergency contraceptives. For each 30 day supply.	Paid according to the tier of drug in the schedule of benefits, above	Paid according to the tier of drug in the schedule of benefits, above
Preventive care drugs and supplements		
For each 30 day supply filled at a **retail pharmacy**	$0 per **prescription** or refill	Paid according to the tier of drug in the schedule of benefits, above
Limitations: Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, see the *How to contact us for help* section.		
Risk reducing breast cancer prescription drugs		
For each 30 day supply filled at a **retail pharmacy**	$0 per **prescription** or refill	Paid according to the tier of drug in the schedule of benefits, above
Limitations: Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered risk reducing breast cancer **prescription drugs**, see the *How to contact us for help* section.		

Tobacco cessation prescription and over-the-counter drugs		
For each 30 day supply filled at a **retail pharmacy**	$0 per **prescription** or refill	Paid according to the tier of drug in the schedule of benefits, above
Limitations: • Coverage is limited to two, 90-day treatment programs only. Any additional treatment programs will be paid according to the tier of drug per the schedule of benefits, above. • Coverage only includes **generic drug** when there is also a brand-name drug available. • Coverage is subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered tobacco cessation **prescription drugs** and OTC drugs, see the *How to contact us for help* section.		
Important note: See the *Outpatient prescription drugs, Other services* section for more information on other **prescription drug** coverage under this plan.		
If you or your **prescriber** requests a covered **brand-name prescription drug** when a covered **generic prescription drug** equivalent is available, you will be responsible for the cost difference between the **generic prescription drug** and the **brand-name prescription drug**, plus the cost share that applies to **brand-name prescription drugs**.		