Preferred Provider Organization (PPO)

Innovation Health Leap Silver Plus Plan

Underwritten by Innovation Health Insurance Company in the state of Virginia

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-844-241-0208.

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

Aetna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Aetna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Aetna:

• Provides free aids and services to people with disabilities to communicate effectively with us, such as:

  ○ Qualified sign language interpreters

  ○ Written information in other formats (large print, audio, accessible electronic formats, other formats)

• Provides free language services to people whose primary language is not English, such as:

  ○ Qualified interpreters

  ○ Information written in other languages

If you need these services, contact our Civil Rights Coordinator.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PO Box 14462, Lexington, KY 40512, 1-800-648-7817, TTY 711, Fax 859-425-3379, CRCoordinator@aetna.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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.

Language Assistance

TTY:711

For language assistance in English call 1-844-241-0208 at no cost. (English)

Para obtener asistencia lingüística en español, llame sin cargo al 1-844-241-0208. (Spanish)

欲取得繁體中文語言協助，請撥打1-844-241-0208，無需付費。(Chinese)

Pour une assistance linguistique en français appeler le 1-844-241-0208 sans frais. (French)

Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-844-241-0208 nang walang bayad. (Tagalog)

Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-844-241-0208 an. (German)

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للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني1-844-241-0208 .)Arabic(

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(Hindi) □□□□□□ म□□ □□ष□ स□□□ क □□ए, 1-844-241-0208 पर म□□ त □□□ कर□□।

Maka enyemaka asụsụ na Igbo kpọọ 1-844-241-0208 na akwụghị ụgwọ ọ bụla (Ibo)

한국어로 언어 지원을 받고 싶으시면 무료 통화번호인1-844-241-0208 번으로 전화해 주십시오. (Korean)

Ɓɛ́ m̀ ké gbo-kpá-kpá dyé pídyi ɖé Ɓǎsɔ́ɔ̀-wùɖù̀ǔn wɛ̃ɛ, ɖá 1-844-241-0208 (Kru-Bassa)

برای راهنمایی به زبان فارسی با شماره 1-844-241-0208 بدون هیچ هزینه ای تماس بگیرید. انگلیسی (naisien)

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-844-241-0208. (Russian)

1-844-241-0208 کے لیے معاونت زبان میں اردو پر مفت کال کریں۔ (uidU)

Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-844-241-0208. (Vietnamese)

Fún ìrànlọwọ nípa èdè (Yorùbá) pe 1-844-241-0208 lái san owó kankan rárá. (Yoruba)

Important Information about the Affordable Care Act (ACA)

Non-discrimination Rule

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

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

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

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

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

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

  to a person because of race, color, national origin, sex, age, or disability.
- Shall not:
  - Deny or limit coverage
  - Deny or limit coverage of a claim
  - Apply additional cost sharing

  to a transgender person, if it results in discrimination against that person.
- Shall not exclude or limit health services related to gender transition.

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

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 basis 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.

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

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

This notice provides a **brief summary** of the Virginia Life, Accident and Sickness Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Virginia law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that a life, annuity or health insurance company licensed in the Commonwealth of Virginia becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Virginia law, with funding from assessments paid by other life and health insurance companies licensed in the Commonwealth of Virginia.

The basic protections provided by the Association are:

Life Insurance
- $300,000 in death benefits;
- $100,000 in cash surrender or withdrawal values.

Health Insurance
- $500,000 in hospital, medical and surgical insurance benefits;
- $300,000 in disability income insurance benefits;
- $300,000 in long-term care insurance benefits;
- $100,000 in other types of health insurance benefits.

Annuities
- $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $350,000, except for hospital, medical and surgical insurance benefits, for which the limit is increased to $500,000.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also limitations on various residency requirements and other limitations under Virginia law.

To learn more about the above protections, please visit the Association's website at www.valifega.org or contact:

VIRGINA LIFE, ACCIDENT
AND SICKNESS
INSURANCE GUARANTY
ASSOCIATION c/o APM
Management Services, Inc.
1503 Santa Rosa Road, Suite 101
Henrico, VA 23229-5105
804-282-2240

STATE CORPORATION
COMMISSION Bureau of
Insurance
P. O. Box 1157
Richmond, VA 23218-1157
804-371-9741
Toll Free Virginia only:
1-800-552-7945
http://scc.virginia.gov/boi/index.aspx

Insurance companies and agents are not allowed by Virginia law to use the existence of the Association or its coverage to encourage you to purchase any kind of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Virginia law, then Virginia law will control.

INNOVATION HEALTH INSURANCE COMPANY

3190 Fairview Park Drive, 5th Floor, Suite 570
Falls Church, VA 22042

Preferred Provider Organization (PPO) Medical Policy

This policy is by and between **Innovation Health Insurance Company** (called **Innovation Health,** we, us, our) and the policyholder (you).

Your coverage starts on the policy effective date and will continue until it ends as described in this policy. See Insert A of this policy for more details.

This policy provides coverage for services and supplies described as **covered benefits**. You may get health care services or **prescription drugs** that might not be **covered benefits** under your policy. Please read your policy and the schedule of benefits because they explain your benefits in detail.

This policy is underwritten by Innovation Health Insurance Company and governed by federal laws and the laws of Virginia.

Please Note: Our plan will pay benefits first. The Virginia Department of Medical Assistance Services is the payer of last resort.

Right to examine the policy: You have 10 days after you receive this policy to read and review it. During that 10-day period, if you decide you do not like the policy, you may return it to us at our home office or to the agent who sold it to you. As soon as it is returned, this policy will be void from the beginning. **Premium** paid will be promptly paid back to you.

Guaranteed Renewable: You can renew this policy each year ("guaranteed renewable"). We decide the **premium** rates. However, we may decide not to renew the policy under certain conditions, which are explained in this policy, or when required by law. See the *When coverage ends* section of the policy for more information.

We may refuse renewal based on one or more of the following:

- You fail to pay premiums in accordance with the terms of this policy
- You perform an act or practice that constitutes fraud or make an intentional misrepresentation of material fact under the terms of the coverage
- We cease to offer this type of health insurance policy in Virginia or ceases to offer any individual coverage in the individual health insurance market in Virginia, in either case in accordance with applicable law

At your option, you may renew this policy by paying the required premium by the end of the grace period of any premium due date.

See the *What does the policy cost you* section of the policy for more information.

Read your policy carefully: This policy is a legal contract between you and us**.** This policy is issued in consideration of the application and payment of the required **premium**. We will pay eligible **covered benefits** while this policy is in force and after the policy terms have been met.

Your Application: You can get a copy of your application by contacting us at the toll-free number on your member ID card.

Entire Contract: The schedule of benefits, Insert A, and any attached papers are included with this policy. These documents are the entire contract between us and you. No change in this policy shall be valid until approved by an executive officer of **Innovation Health** and included in or attached to this policy. No agent has authority to change this policy or to waive any of its provisions.

David Notari
Chief Executive Officer
Innovation Health Insurance Company

Welcome

Thank you for choosing us.

This is your policy. It is one of two documents that together describe what benefits you have under the terms of the policy.

This policy will tell you about your **covered benefits** – what they are and how you get them. 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 policy covers only a certain number of visits.

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

Welcome to your **Innovation Health** policy.

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Let's get started!

Here are some basics. First things first – some notes on how we use words. Then we explain how your policy 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 policy 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 the policyholder as defined in Insert A.
- 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 policy does – providing covered benefits

Your policy provides **covered benefits**. These are **eligible health services** that your policy has an obligation to pay.

How your policy works – starting and stopping coverage

Your coverage under the policy has a start and an end. After you complete the eligibility and enrollment process and the policy has been issued, your coverage starts on the policy effective date. (see the policy effective date on Insert A). Coverage is not provided for any services received before coverage starts or after coverage ends.

Your coverage typically ends when we no longer pay your **premium**. To learn more see the *When coverage ends* section.

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

How your policy 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 called **eligible health services**.
- You will pay less cost share when you use a **network provider**.

1. **Eligible health services**
   Doctor and **hospital** services are the foundation for many other services. You'll probably find the preventive care, **emergency services** and **urgent condition** coverage especially important. But the policy 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 are listed in the ***Eligible health services*** *under your policy* section.
- They are not listed in the *What your policy doesn't cover – exceptions and exclusions* section. (We will refer to this section as the "exceptions" section in the rest of this policy.)
- They are not beyond any limits in the schedule of benefits.

2. **Providers**

Our network 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.My.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**.

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.

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

3. **Paying for eligible health services – general requirements**

There are several general requirements for the policy 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 provider**.
- 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 policy and you will share the expense of your **eligible health services** when you meet the general requirements for paying.

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

5. **Disagreements**
   We know that people sometimes see things differently.

   The policy 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 make the final decision for us.

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

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

The section above told you how your policy works while you are covered in-network. You also have coverage when you want to get your care from **providers** who are not part of our network. 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 that 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 you will pay a higher cost share when you use an **out-of-network provider**.

You will find details on:

- **Precertification** 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 policy pays and what you pay* section, and your schedule of benefits.
- Claim information in the *When you disagree - claim decisions and appeals procedure* section.

How to contact us for help or important information about your insurance

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

- logging onto your secure member website at www.My.innovationhealth.com.
- Register for our secure Internet access to reliable health information, tools and resources. Online tools can 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 us toll-free at 844-289-4503
- Writing us at
  Innovation Health Insurance Company
  PO Box 981106
  El Paso, TX 79998-1106

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.

Your member ID card

Your member ID card tells doctors, **hospitals**, and other **providers** that you are covered by this policy. 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 insured dependents can use your member ID card. If you misuse your card we may end your coverage.

To get your digital ID card, log into your secure member website at www.My.innovationhealth.com. Your can print your ID card from here. You can also call Member Services and ask us to mail you an ID card.

Inform us of any changes

It is important that you notify us of any changes that might affect your policy. 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
- You or your covered dependent get health coverage through a job-based plan or a program like Medicare, Medicaid or the Children's Health Insurance Program (CHIP)

It is important that you notify us within 31 days if you change your address. If you move within the **service area, premium** rates will be adjusted, if needed, for your new address and the current ages of your covered dependents. This will happen at the beginning of the **premium period** after the change of address.

See the *Special times you or your dependent can join the policy* section for information on special or limited enrollment periods.

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.

What does the policy cost you?

Premium payment

This policy requires you to make **premium** payments. We will not pay benefits under this policy for services obtained following termination of coverage if **premium** payments are not made by the end of the grace period. Any benefit payment denial is subject to our appeals procedure. See the *When you disagree - complaints and appeals procedures* section of this policy.

The first **premium** payment is due on or before your or your insured **dependent's effective date of coverage**. The cost of your and your insured **dependent** coverage is listed on the *Insert A*. When we calculate the **premium** you owe, we use our records to determine who is covered under the policy. You owe **premium** for each person covered under the policy starting with the **premium** due date on or after the day the person's coverage starts. You stop paying **premium** as of the next **premium** due date on or after the day the person's coverage ends.

After your first **premium** payment is made, **premium** payments are due on the 1st or 15th of each month based on your **effective date of coverage**. Each **premium** payment is to be paid to us on or before the due date. Your **premium** becomes overdue following the last day of the **premium** period.

We provide this policy to you and you pay **premium** to us. We may choose not to accept **premium** that is paid for you by someone else unless we are required by law.

Grace period

You will be allowed a grace period of 31 days after the due date for the payment of each **premium** due after the first **premium** payment. Your coverage will remain in force during the grace period. If **premiums** are not paid by the end of the grace period, your coverage will automatically terminate at the end of the grace period. We will reinstate it if you request in writing and pay the entire **premium** due. Call us for instructions. See the *How to contact us for help* section.

Premium agreement

Your premium rate will not change for the initial month of this policy as long as there are no changes to this policy. This is called a guaranteed period. Changes include things like the area you live in, the benefit plan or adding dependents to the policy.

Your **premium** rate is based upon factors such as:

- The plan you are enrolled in
- Your age and the ages of covered dependents
- The number of covered persons
- Tobacco use
- Where you live (address)

Premium rates are expected to change over time as the cost of healthcare services change. Each **premium** will be based on the rates in effect on that **premium** due date.

In the event of any changes in **premium** rates, payment of the **premium** by you means that you accept the **premium changes**.

In the event a **premium** payment check is returned or dishonored by the bank as non-payable to us for any reason, you may be responsible for an additional charge.

Who the policy covers

You will find information in this section about:

- Who is eligible
- Who can be your dependent
- When a dependent can be added to your policy
- Special times you or your dependent can join the policy
- **Effective date of coverage** for your dependent

Who is eligible

You are eligible as the policyholder when you are:

- Living, working or residing in the **service area**
- Not enrolled in Medicare at the time of application
- Listed as the applicant on the application
- Approved by **us**

You are enrolled as the policyholder after you complete the eligibility and enrollment process, and we have issued the policy to you.

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

You can enroll the following family members on your policy. (They are your "dependents".) A dependent must be approved by us:

- Your legal spouse
- Your domestic partner. Your domestic partner must meet the following criteria:
  - Be your sole domestic partner and intends 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 intend 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
    - Any children approved by us

When a dependent can be added to your policy

You can enroll your dependent:

- at initial enrollment or annual enrollment
- at other special times during the year as listed below

Special times you or your dependent can join the policy

Federal law allows you or your dependents to enroll at times other than when you originally enrolled as the policyholder. This is called a special or limited enrollment period. You or your dependent can enroll in these situations when:

- You or your dependent has lost minimum essential coverage.
- You have added a dependent because of marriage, birth, adoption or foster care. See the *Adding new dependents* section (below) for more information.
- You or your dependent is enrolled in an non-calendar year group health plan or individual health insurance coverage.
- You or your dependent's enrollment or non-enrollment in a plan through the Health Insurance Marketplace is not intended, by accident or a mistake and is because of an error, false information or delay by the marketplace.
- You or your dependent has complained to the marketplace that their plan did not honor or maintain an important provision of its contract with you.
- You did not enroll them in this policy before because they had other coverage and now that other coverage has ended.
- You want to cover a current spouse, domestic partner or a child on your health policy.
- You or your dependent is now eligible or not eligible for the **premium** tax credit or change in eligibility or cost share reduction, for marketplace coverage.
- You or your dependent has access to new plans because you have moved to a new permanent location.
- You or your dependent becomes eligible for State **premium** assistance under Medicaid or an S-CHIP plan for the payment of your **premium** contribution for coverage under this plan.
- You or your dependent loses your eligibility for enrollment in Medicaid or an S-CHIP plan.

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

Adding new dependents

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

- A spouse - If you marry, you can put a spouse on your policy.
  We must receive your completed enrollment information and additional **premium** not more than 60 days after the date of your marriage.
- A domestic partner - If you enter a domestic partnership, you can add a domestic partner to your policy.
  - We must receive your completed enrollment information and additional **premium** not more than 60 days after the date you file a Declaration of Domestic Partnership. You can call us to obtain a Declaration of Domestic Partnership form.
  - Coverage will be effective on the first day of the month following plan selection.
- A newborn child or grandchild - Your newborn child or grandchild is covered by your policy for the first 31 days after birth.
  - To keep your newborn covered, we must receive your completed enrollment information and additional **premium** 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** for the new dependent.
  - If you miss this deadline, your newborn will not have benefits after the first 31 days.
- An adopted child – An adopted child is covered on your policy 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. A child whose adoptive or parental placement has occurred within thirty-one days of birth will be considered a newborn child of the insured as of the date of the adoptive or parental placement.
  - To keep your adopted child insured, we must receive your completed enrollment information and additional **premium** within 60 days after the date of the adoption or the date the child was placed for adoption.
  - If you miss this deadline, your adopted child or child in process of adoption, will not have benefits after the first 31 days.
- A stepchild - You may put a child of your spouse, or domestic partner on your policy.
  - You must complete your enrollment information and send it to us within 60 days after the date of your marriage or your Declaration of Domestic Partnership with your stepchild's parent along with the additional **premium** required.
- A foster child - A foster child is covered on your policy 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 and additional **premium** within 60 days after the date the child is placed with you.
  - If you miss this deadline, your foster child will not have benefits after the first 31 days.

Effective date of coverage for your insured dependent

Your dependent coverage will be in effect on your **effective date of coverage**, if you enrolled them at that time, otherwise:

- As shown above under the *Adding new dependents section*
- 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

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

Your policy 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 requ[illegible] **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 **medical necessity** and **in-network precertification** requirements for **network providers**. 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 a **covered benefit** under this policy.

The **medical necessity** requirements are stated in the *Glossary* section, where we define "**medically necessary, medical necessity**." That is where we also explain what our medical directors or their **physician** designees 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 [illegible] is responsible for obtaining any necessary **precertification** before you get the care. If your **physician** or [illegible] 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 policy won't pay for it. You will find details on requirements in the *What the policy pays and what you pay – exceptions – when you pay all* section.

If your **physician** requests **precertification** and we refuse it, you or your **physician** can appeal. See the *When you disagree - when you disagree - claim decisions and appeals procedures* section.

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 policy 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 **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-[illegible]025
- 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 policy

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

Your policy 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.

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

1. Preventive care and wellness

This section describes the **eligible health services** and supplies available under your policy 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

   These recommendations and guidelines may be updated periodically. When these are updated, they will be applied to this policy. 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 will not be covered under the preventive care benefit. For those tests, 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.

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 also includes:

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force

- Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.
- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
    - Screening and counseling services on topics such as:
        - Interpersonal and domestic violence
        - Sexually transmitted diseases
        - Human Immune Deficiency Virus (HIV) infections
    - Screening for gestational diabetes for women
    - High risk Human Papillomavirus (HPV) DNA testing for women age 30 and older
- 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 policy 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 policy 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 policy 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
  - Risk 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 can

Routine cancer screenings

Eligible health services include the following routine cancer screenings:

- Diagnostic mammograms
- 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 gynecological 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 further define likelihood of genetic and/or chromosomal anomalies.

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

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

Comprehensive lactation support and counseling services

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

Breast pumps and 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 policy will cover this cost once every three years, or
    - A manual breast pump. Your policy will cover this cost once per **calendar 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 out of 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. Including 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 & 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 would 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 treat 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 web cam, chat or voice.

Other **eligible health 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
- Diagnostic hearing and vision tests
- Radiological supplies, services, and tests
- Chronic disease management

Physician surgical services

Eligible health services include charges of:

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

Alternatives to physician office visits

Walk-in clinic

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

- Unscheduled, non- emergency **illnesses** and **injuries**
- The administration of immunizations administered within the scope of the clinic's license
- Individual screening and counseling services to aid 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 the 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 all hospital services 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** can be done safely in a **physician's** office. For those **surgeries**, your policy 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 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 or medical social services, or are 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 provided in the home under the home health care benefit 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
- Palliative care
- 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 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 in the home under the hospice benefit are not subject to the conditions and limitations imposed on th[illegible] provided outside the home. See the *Rehabilitation services and Habilitation therapy services* section and the Schedule of benefits.

Skilled nursing care

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

Your policy also covers private duty nursing provided by an **R.N.** or **L.P.N.** for non-hospitalized **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**
- 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.
- 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**.

As always, you can get emergency care from **network providers**. However, you can also get emergency care from **out-of-network providers**.

Your coverage for **emergency services** and urgent care from **out-of-network providers** ends when your condition is stabilized and we and the attending **physician** 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- **Emergency services** and urgent care and **Precertification** benefit reduction* sections for specific policy details.

In case of an urgent condition

Urgent condition

If you need care for an **urgent condition**, you should first seek care through your **physician.** If your **physician** 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 policy may not cover your expenses. See the *exception –**Emergency services** and urgent care and **Precertification** benefit reduction* sections and the schedule of benefits for specific policy 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** may cost you more. To get the maximum level of benefits, services should be provided by your **network provider.**

What rules and limits apply to dental care?

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

When does your policy 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:
  - Craniofacial microsomia
  - Craniosynostosis syndromes
  - Cleidocranial dental dysplasia
  - [illegible] type
  - 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 policy cover replacements?

Crowns, inlays, onlays and veneers, complete dentures, removable partial dentures, fixed partial dentures (bridges) and other prosthetic services are subject to the policy'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 policy cover missing teeth that are not replaced?

The first 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 for 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
- Services for 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 as 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** directs it as part of a treatment plan.

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 services, 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

See the *Outpatient prescription drugs* section for diabetic supplies that you can get at a **pharmacy**.

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

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 shares 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 tests
  - Treatment for complications of pregnancy
- 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

(You may choose a shorter **stay**, if the attending **physician**, with your consent, discharges you or your 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 follo

- **Inpatient room and board** at the **semi-private room rate**, and other services and supplies related to your condition that are provided du[illegible]r **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 counselor.
  - Medication management visits to monitor and adjust drugs prescribed for a mental disorder
  - 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 that are 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.
- Medication management visits to monitor and adjust drugs prescribed for a **substance use disorder**.
- 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 function of 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 which 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. **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; or
    - The purpose of the **surgery** is to improve function.

Transplant services

Eligible health services include organ and tissue transplant and transfusion 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 determined by 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 basic infertility

Eligible health services include basic **infertility** care, including seeing a **network provider** to diagnose and treat 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 $[illegible]00
- Professional services to read the scan

Complex imaging for preoperative testing is covered und[illegible]his bene[illegible]

Diagnostic lab work

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

Diagnostic radiological se[illegible]ces

Eligible health services include radi[illegible]log[illegible] ervice[illegible] (other[illegible]han diagnostic complex imaging) only when you get them from a licensed radiological [illegible]ty. **Eligible health services** include:

- X-ray
- Mammogram
- Ultrasound
- Nuclear medicine
- EE[illegible]
- Echocardiogram
- EKG
- [illegible]al se[illegible]ces 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 radiation therapy, chemotherapy and immunotherapy. 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** in the *How to contact us for help* section to determine if coverage is under the outpatient **prescription drug** section or the medical section.

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

Dialysis

Eligible health services for dialysis 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,** and
- 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 policy.

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 injected and 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 a 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 is 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 spirometer
- 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
- A **hospital**, **skilled nursing facility**, outpatient rehabilitation facility or **hospice facility**
- A **home health care agency**
- A **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
- [illegible] 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
  - Neruo 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. It also includes therapy for tasks needed for the person's job. Occupational therapy does not include educational therapy, vocational rehabilitation or employment counseling.
- Speech therapy to:
    - Identify, assess, teach, improve or restore the speech function or correct a speech impairment as a result of an **illness, injury, surgical procedure** or prior medical treatment
    - Improve delays in speech function development caused by a birth defect.
    - Teach, keep, learn or improve skills needed for daily living, such as therapy for a child who is not talking at the expected age.
    - Develop communication or swallowing skills to correct a speech impairment.
    - Assist with swallowing disorders in children and adults.

  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 and
    - 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 through 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 performed 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** you need.
- 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 h**ospital**, sk**illed** n**ursing** f**acility** or ac**ute** rehabilitation h**ospital**, an a**mbulance** is required to safely and adequately trans**port** you to or from inpatient or outpatient m**edically** n**ecessary** treatment.

Your policy also covers emergency transportation to a **hospital** by fixed wing or rotary wing air transportation or by water **ambulance** 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 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 instruction and appropriate services needed for a **member** to properly use the item, such as attachment or insertion.

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:

- 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
- Hypodermic needles and syringes
- 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 stock 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 abnormalities, 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 precertify the device.

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, BiPAP 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 **calendar year** this benefit will cover either **prescription** lenses for eyeglass frames or **prescription** contact lenses, but not both.

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
- "Pinhole" glasses that are prescribed for use after surgery for a detached retina
- 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 policy
- 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 *How can I request a medical exception* section.

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 **recognized charges**
- Submitting your own claims

Eligible health services under your policy

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

- They are listed in the ***Eligible health services*** *under your policy* 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 policy'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 includes drugs listed in the **preferred drug guide. Prescription drugs** not in the **preferred drug guide** are excluded unless a medical exception is approved by us. If it is **medically necessary** for you to use a **prescription drug** not on the **preferred drug guide**, you or your **prescriber** must request a medical exception.

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 other requirements or limitations established by us. **Prescription drugs** covered by this policy 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 **pharmacy.**
- Calling or e-mailing a **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 calculate your cost sharing. 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**.

See the schedule of benefits for details on supply limits and cost sharing.

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 for contraceptive use 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 ring
- Transdermal contraceptive patches
- Female contraceptive devices and implants including the related services and supplies to administer the device
- FDA approved female generic emergency contraceptives
- Other FDA approved female 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 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 agents
- 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 policy, 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.My.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.
- 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 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**
- Compounded **prescriptions** will be subject to a non-preferred **copayment**

What precertification requirements apply

Why do some drugs need precertification?

For certain drugs, 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 drug** 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 seek a medical exception to get health care services for drugs not listed on the **preferred drug guide** or **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. Any exception granted is based upon an individual case by case decision, and will not apply to other members.

We will grant a medical exception for a non-preferred drug if, after reasonable investigation and consultation with your **prescriber**:

- The covered drug is determined to be an inappropriate therapy for Your medical condition; or
- You have been receiving the specific **non-preferred drug** or drug on the formulary exclusions list for at least six months before the formulary drug limitation took effect and it is determined that the formulary drug is an inappropriate therapy for you or that changing drug therapy presents a significant health risk to you.

We will act on a medical exception request within one business day of receipt of the request and will notify you or your designee and your **prescriber** of our decision.

You, someone who represents you or your **prescriber** may seek a quicker medical exception process to obtain 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 PA 1300 E Campbell Road Richardson, TX 75081
- We will make a coverage determination within 24 hours after receipt of your request and will notify you or your designee and your **prescriber** of our decision. If approved by us the exception will be granted for the duration of the exigency.

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 your claim decision is one for which you can seek 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 notify you, your designee or your **prescriber** of the coverage determination of the external review later than 72 hours after receiving your request. If the medical exception is approved, coverage will be provided for the duration of the **prescription**. For quicker medical exceptions in urgent situations, we will notify you, your designee or your **prescriber** of the coverage determination no later than 24 hours after receiving 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 outpatient **prescription drugs** are subject to quantity limits. These quantity limits help your **prescriber** and pharmacist check that your outpatient **prescription drug** is used correctly and safely. We rely on medical guidelines, FDA-approved recommendations from drug makers and other criteria developed by us to set these quantity limits.

Any **prescription drug** that is made to last 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 policy 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 policy in the ***Eligible health services*** *under your policy* section. In that section we also told you that some of those health care services and supplies have exceptions and some are not covered at all (exclusions).

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

And just a reminder, you'll find coverage limitations in the schedule of benefi

Exceptions and exclusions

The following are not **eligible health services** under your policy except as describ in the *Eligib health services under your policy* section of this policy or by a rider or amendment included this olicy:

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

Ambulance services

- Ambulance services, for routine transportation receive outpatient or inpatient services.

Autism spectrum disorder

- Early intensive behavioral interventions (includ Applied Behavioral Analysis, Denver, LEAP, TEACCH, Rutgers, I) and other inte ve educational interventions.

Artificial organs

- Any device tha ould perform the unction of a body organ.

Blood services, synthet c blo , od derivatives or substitutes

Examples of these are:

- The provision of blo d to the **hospital**, other than blood derived clotting factors
- Any related services including processing, storage or replacement expenses
- lood donors, apheresis or plasmapheresis

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

Clinical trial the ies (experimental or investigational)

- Your policy does not cover clinical trial therapies (**experimental or investigational**), except as described in the ***Eligible health services*** *under your policy - Clinical trial therapies (experimental or investigational)* section.

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, toileting, eating or preparing foods.
- Any other services that a person without medical or paramedical training could be trained to perform.
- Any service that can be performed by a person without any medical or paramedical training.

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

Dental care for adults

- Dental services related to:
  - Routine care, fillings, removal or replacement of teeth and treatment of diseases of the teeth
  - Dental services related to the gums
  - Apicoectomy (dental root resection)
  - 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 sheltered hard working 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.

This exclusion does not apply to diabetes or lymphedema training or any educational services covered under ***Eligible health services*** *under your policy – Preventive care and wellness*.

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*, any health or dental examinations needed:

- Because a third party requires the exam. Examples are, 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). See the ***Eligible health services*** *under your policy – Other services* section.

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

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 condoms
- Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA
- Male contraceptive methods or devices
- Services and supplies provided for an abortion (voluntary termination of pregnancy) , except when the life of the mother is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself, or when the pregnancy is the result of an alleged act of rape or incest
- The reversal of voluntary sterilization procedures, including any related follow-up care

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.
- Any service unless provided in accordance with a specific treatment plan.
- 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 and skilled behavioral health services in the home

- Services provided outside of the home (such as in conjunction with school, education, 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 (filling)
- [illegible] (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/ substance use disorder treatment

- **Mental health/substance use disorder** 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
  - Specific delays in development (learning disorders, academic underachievement)
  - Intellectual disability
  - Wilderness Treatment Program or any such related or similar program
  - School and/or education services
- Transportation

Nutritional supplements

- Any food item, including formulas, nutritional supplements, vitamins, plus **prescription** vitamins, medical foods and other nutritional items except as covered in the ***Eligible health services*** *under your policy – Other services* section or the ***Eligible health services*** *under your policy – Outpatient* ***prescription drugs*** section.

Obesity (bariatric surgery)

- Any weight management treatment, drug, service or supply 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 policy – 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 comorbid 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, and other services and supplies that are 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 or food supplements, appetite suppressants and other medications
  - Coaching, training, 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 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** and covered under your outpatient **prescription drug** plan in the ***Eligible Health Services*** *under your policy –Outpatient prescription drug- Specialty* ***prescription drugs*** section.

Outpatient prescription drugs

- Abortion drugs provided during a procedure to terminate pregnancy. If the abortion is covered medications will be covered under the ***Eligible health services*** *under your policy-hospital* 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 administration 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 injection equipment* section.
- **Brand-name prescription drugs** and services when a **generic prescription drug** equivalent, **biosimilar prescription drug** or **generic prescription drug** alternative is available, unless otherwise covered by medical exception
- **Cosmetic** drugs, applications 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]), even if a **prescription** is written unless recommended by the United States Preventive Services Task Force (USPSTF) and as described in the ***Eligible health services*** *under your policy – Outpatient* ***prescription*** *contraceptive drugs*.
  - That include the same active ingredient or a modified version of an active ingredient
  - That is therapeutically equivalent or therapeutically alternative to a covered **prescription drug** (unless a medical exception is approved)
  - Is therapeutically equivalent or therapeutically 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.

- Recently approved by the U.S. Food and Drug Administration (FDA), but which have not yet been reviewed by our Pharmacy and Therapeutics Committee. However, no **prescription drug** will be excluded from coverage solely on the basis of the length of time since the drug obtained FDA approval.
- That are 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 or to 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 policy – Outpatient prescription drugs- Contraceptive drugs* section
- **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 except where stated in the *Eligible health services under your policy - Diabetic equipment, supplies and education* and *Durable medical equipment (DME)* sections.
  - Injectable drugs, except insulin, 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 policy 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.My.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:**
  - For which there is an over-the-counter (OTC) product which has the same active ingredient and strength even if a **prescription** is written.

- Filled prior to the effective date or after the end date of coverage under this policy.
- That include an active metabolite, stereoisomer, prodrug (precursor) or altered formulation of another drug and is not clinically superior to that drug as determined by the policy.
- That are considered oral dental preparations and fluoride rinses, except pediatric fluoride tablets or drops as specified on the **preferred drug guide (formulary)**.
- 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 (formulary)** or the product on the **preferred drug guide (formulary)** 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, or not **medically necessary**, 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 (formulary)** 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 (formulary)** 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 (formulary)** 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 jurisdiction 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).
- Test agents except diabetic test agents
  - Over-the-counter home test kits

Outpatient surgery

- The services of any other **physician** who helps the operating **physician**
- A **stay** in a **hospital (hospital stays** are covered in the ***Eligible health services*** *under your policy –* ***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 except as covered under the ***Eligible health services*** *under your policy- Reconstructive surgery and supplies* section.
  - 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 policy* 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 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 used:
  - To alter vertical dimension
  - To restore occlusion, or
  - For correcting attrition, abrasion, abfraction or erosion
- Orthognathic **surgery**, and treatment of malocclusion, devices to alter bite or alignment except when covered as **medically necessary** orthodontic treatment
- General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another **covered health service**
- Orthodontic treatment except as covered in the *Eligible health services under your policy – Pediatric dental care* section
- Prescribed drugs or pre-medication
- Replacement of prosthesis or appliances 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, except for replacement of lost or broken retainer
- Replacement of teeth beyond the normal complement of 32
- Routine dental exams and other preventive services and supplies, except as specifically provided in the Schedule of Benefits.
- 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 any other person, including a provider.
  - Provided in connection with treatment or care that is not covered under the 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 inpatient 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, except those needed after surgery or injury
- 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 provided by a **physician**, or treatment covered as part of the spinal manipulation benefit
    - This applies whether or not benefits have been 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 policy.

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 care 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 in the ***Eligible Health Services*** *under your policy - outpatient* ***prescription drugs*** section.

Strength and performance

- Services, devices and supplies such as drugs or preparations designed primarily for the purpose of enhancing 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 as specifically provided in the ***Eligible health services*** *under your policy – Preventive care and wellness* section
  - Hypnosis and other therapies
  - Medications, except as specifically covered in the ***Eligible health services*** *under your policy – 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 for which there is no charge made to the recipient, 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 retrieval or transfer.
  - 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 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**.**
- Ovulation induction with Pergonal, 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*

- Any non-**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

Except as covered in ***Eligible health services*** *under your policy- Visions correction after surgery or accident*

- Routine vision exam provided by an ophthalmologist or optometrist including refraction and glaucoma testing and vision care services and supplies
- Eyeglass frames and **prescription** and non**-prescription** lenses and contact lenses
- 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
- Exams for contact lenses o their fitting
- Laser in-situ keratomileusis (LASIK) radial keratotomy or related procedures designed to surgically correct refractive errors
- Duplicate or spare eyeglasses or lenses or frames
- Replacement of lenses or frames that are lost or stolen or broken
- Acuity tests
- 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 injury

- 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 will be 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, 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 policy 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**.

Network providers

We have contracted with **providers** to provide **eligible health services** to you. These **providers** make up the network for your policy. 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 policy* section.
- Urgent care – refer to the description of emergency services and urgent care in the ***Eligible health services*** *under your policy* section.

You may select a **network provider** from the **directory** or by logging on to our website at www.My.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 policy owes.

Your primary care physician (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 policy:

- 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 their own **PCP.** You may each select your own **PCP**. You should select a **PCP** for your insured 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 numb[illegible] on your ID card or log on to your secure member website at www. My.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 [illegible] 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**

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

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

- You join the policy and your **provider** you have now is not in the network.
- You are already our 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 Coverage Request form and send it to us. Call Member Services at the number on 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 for up to 90 days. This date is based on the date the **provider** terminated their participation with us**.**
How claim is paid	Your claim will be paid at the **network provider** cost sharing level.	Your claim will be paid at the **network provider** cost sharing level.

If you are pregnant and have entered 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**.

What the policy pays and what you pay

Who pays for your **eligible health services** – us under this policy, 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

The policy and you share the expense up to any **maximum out-of-pocket limit**. The schedule of benefits lists how much your policy pays and how much you pay for each type of health care service. When you get **eligible health services**:

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

Or

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

And then

- The policy 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 a **non-network provider**. See the *Glossary* section for what these terms mean.

Important exception – when your policy pays all

Your policy pays the entire expense for all **eligible health services** under the preventive care and wellness benefit.

Important exceptions – 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 policy requires **precertification**, your **physician** requested it, 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**. You can appeal any determination that a service is not **medically necessary** or when **precertification** is denied. See adverse benefit determinations under the *When you disagree - claim decisions and appeals procedures* section.

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

Where your schedule of benefits fits in

How your deductible works

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

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 which **copayments/coinsurance** you need to pay for specific **eligible health services**.

Except for preventive care and wellness, you will pay the **physician copayment/coinsurance** when you receive **eligible health services** from an **OBGYN**.

You will pay less cost sharing when you use a **network provider** for **eligible health services** from them. Your cost sharing will be generally higher when **out-of-network providers** are used.

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 policy. Your schedule of benefits shows the **maximum out-of-pocket limits** that apply to your policy. Once you reach your **maximum out-of-pocket limit**, your policy will pay for **covered benefits** for the remainder of the **calendar year**.

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

When you disagree - claim decisions and appeals 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 decide 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).	• Claim forms will be furnished by us within 15 days of notification of the claim • You must send written notice of the claim within 20 days after a covered medical expense is incurred or 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.	• Written proof must be given within 90 days after such loss or as soon as reasonably possible, but not later than one year from the time specified, except for in cases where the claimant is legally incapacitated
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.
Important Note: See *General provisions – other things you should know* section for more information.		

Types of claims and communicating our claim decisions

You or your **provider** are required to send us a claim in writing. We will review that claim for payment to the **provider** or to you as appropriate. See *A General provisions – other things you should know-Claim forms* for more information.

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

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

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.

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 (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* 15 calendar days for non-urgent request
Extensions	None	15 days	15 days	Not applicable
If we request more information	24 hours	15 days	30 days	Not applicable
Time you have to send us additional information	48 hours	45 days	45 days	Not applicable

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

Adverse benefit determination

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 deny payment entirely. Any time we deny 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, once under this policy. 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. A **final adverse benefit determination** notice may also provide an option to request an **External Review** *(if available)***.**

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:

- Your 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 your **provider**. This 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.

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 final decision. 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 appeals

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 one level 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 one level appeal 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 of the 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 your control.
  - The violation was part of an ongoing good faith exchange between you and us.

External review

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

You have a right to external review only if:

- Our claim decision involved medical judgment.
- We decided the service or supply is not **medically necessary,** appropriate or effective.
- We decide the service or supply is not the right setting or level of care.
- 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 policy of benefits.
- Send notification of the decision within 45 calendar days of the date we receive your request form and all the necessary information.

We will stand by the decision that the IRO makes.

How long will it take to get an IRO decision?

We will tell you of the assigned IRO decision in no more than 45 calendar days after they 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 determinations

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

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

For final adverse determinations

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 (in the case of **experimental or investigational** treatment), or
- The final adverse determination concerns an admission, availability of care, continued **stay** or health care service for which you received **emergency services**, but have not been discharged from a facility

If your situation qualifies for this faster review, you will receive a decision from the assigned IRO within 72 hours of them getting your request.

Managed Care Ombudsman

If you have any questions regarding an **appeal** or **complaint** regarding the health care services that you have been provided 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 charge any fees for expenses incurred by you in pursuing a complaint or appeal.

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 policy will end if:

- This policy is discontinued.
- You cancel the policy by notifying us in writing. Your coverage will end on the date the notice is received or a later date you state in the notice. We will promptly return the unearned portion of any premium you paid. The earned premium shall be computed pro rata. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.
- You are no longer eligible for coverage
- You no longer live, work or reside in the **service area**
- You do not pay the required **premium** payment by the end of the grace period
- This product is discontinued in the state if approved by the Virginia Bureau of Insurance
- We withdraw from the individual market if approved by the Virginia Bureau of Insurance
- We rescind your coverage, as permitted under this policy

When will coverage end for any dependent?

Coverage for your dependent will end if:

- Your dependent no longer meet the eligibility requirements under the policy
- You do not make the required **premium** contribution toward the cost of **dependents'** coverage by the end of the grace period
- Your coverage ends for any of the reasons listed above

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

- The date this policy no longer allows coverage for domestic partners.
- The date the domestic partnership ends. For a Domestic Partnership you should provide a completed and signed Declaration of Termination of Domestic Partnership to us.

We will send you notice if your or your covered dependents' coverage is ending. This notice will tell you the date that coverage ends. This is how the date is determined:

- Coverage will end for you and any covered dependents immediately on the next **premium** contribution due date following the date on which you no longer meet the eligibility requirements.

Special coverage options after your policy coverage ends

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

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

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

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

- Is not able to be self-supporting because of physical or intellectual disability, and
- 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 after 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 31 days after your death, and
- Payment is made for the coverage.

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

- The end of the 12th month period after your death
- They no longer meet the definition of dependent
- Dependent coverage stops under the plan
- They become covered by another health benefits plan
- Any required contributions stop, or
- The date your spouse remarries

General provisions – other things you should know

Administrative provisions

How you and we will interpret this policy

We prepared this policy according the applicable federal laws and state laws. You and we will interpret it according to these laws. Our interpretation of this policy applies when we administer your coverage, so long as we use reasonable discretion. But you have the right to appeal our decisions as described in the **When you disagree - claim decisions and appeals procedures** section.

How we administer this policy

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

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 **provider**. When **network provider**s are not our employees or agents.

Coverage and services

Your coverage can change

Your coverage is defined by this policy. This document may have amendments or riders too. Under certain circumstances, the law may require a change in your policy. Only we can waive a requirement of your policy. No other person – including your **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 will refund you any unearned **premium**.

Financial sanctions exclusions

If coverage provided under this policy violates or will violate any economic or trade sanctions, the coverage is immediately considered invalid. For example, **Innovation Health** companies cannot make payments for healthcare or other claims or services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or a country under sanction by the United States, unless it is permitted under a written license from the Office of Foreign Asset Control (OFAC). For more information visit http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

Workers' Compensation

If benefits are paid by us and we determine you received worker's compensation benefits for the same incident, we have the right to recover from your employer or workers' compensation insurance carrier an amount equal to the amount we paid.

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.

Benefits not transferable
You and/or your insured dependents are the only persons entitled to receive benefits under this policy.

Conformity with law
Any provision of this policy which, on its effective date, is in conflict with the laws of the state in which the Insured resides is hereby amended to conform with the minimum requirements of such law.

When you are no longer the policyholder
If the policyholder dies or otherwise ceases to be the insured other than by termination of the policy, the policyholder's covered spouse or domestic partner, if any, will become the policyholder. In the case of an insured dependent child, the parent or legal guardian in whose name the coverage under the policy is issued is considered the policyholder. If at the end of a **premium period** there is no policyholder, this policy will terminate.

Child only coverage
In the case of child only coverage, the parent or legal guardian in whose name the coverage under the policy is issued is considered the policyholder. As parent or legal guardian, the policyholder has subscribed on behalf of the child for the benefits described in this policy. It is the policyholder's responsibility to assure a child's compliance with any and all terms and conditions outlined in this policy.

Effect of benefits under other policies
Non-duplication of benefits
If, while covered under this policy, you are also covered by another **Innovation Health** individual coverage policy:

- You will be entitled only to the benefits of the policy with the greater benefits, and
- We will refund any **premium** charges received under the policy with the lesser benefits covering the time period both policies were in effect.

If while covered under this policy, you are also covered under an **Innovation Health** group policy:

- You will be entitled only to the benefits of the group policy, and
- We will refund any **premium** received under the individual policy covering the period both policies were in effect.

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.

Misstatement of age
If the covered person's age was misstated, the benefits will be those the premium paid would have purchased at the correct age.

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 Innovation Health Insurance Company, PO Box 981106 El Paso, TX 79998-1106, or to our authorized agent identifying the policyholder, will be considered notice.

Claim forms
You are required to submit a claim form to us in writing. Claim forms will be furnished to 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.

Proof of loss (claim filing)
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.

Time of payment of claims
Benefits will be paid as soon as necessary proof to support the claim is received. Written proof must be provided for all benefits.

Payment of benefits
All benefits are payable to you. However, **we** reserve the right to pay any health benefits to a **network provider**. This will be done unless you have told us otherwise by the time you file the claim (see proof of loss).

When a claim is paid, any premium due and unpaid may be deducted from the claim payment.

When a **network provider** provides care to you or a covered dependent, the **network provider** will take care of filing claims for you. However, when you seek care on your own (**out-of-network services and supplies**), you are responsible for filing your own claims.

Other insurance coverage
If you have other valid coverage providing benefits for the same loss and we have not been given written notice of this coverage prior to the loss, our only liability will be for an equal share of the amount which would otherwise have been payable under the policy if we had prior knowledge of the coverage. Our equal share is calculated by adding the total of the like amounts (same benefits) of all other valid coverages (those previously known and the newly learned). After determining our proportionate share of the benefit payment, we will return to you any pro-rated premium you paid that exceeded the amount of coverage determined under their policy.

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**, **dental providers** and others who furnish services
- Dates expenses are incurred
- Copies of all bills and receipts

Honest mistakes and intentional deception

Honest mistakes

You may make an honest mistake in your application for coverage. When we learn of the mistake, we will tell you what the mistake was.

We will not use any statement made in the application to contest the policy.

Intentional deception

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

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

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 **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.

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 policy 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 properly licensed or certified to provide diagnostic and/or therapeutic services for **mental disorder** 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** notwithstanding 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
A U.S. Food and Drug Administration (FDA) approved **prescription drug** with a branded name assigned to it by the manufacturer or distributor, and designated by Multi-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 policy.

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 calendar year before your policy 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 alcohol or drug dependent, person is assisted through the period of time needed to eliminate the:

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

This could 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 policy. The most up-to-date directory for your policy appears at http://www.innovation-health.com/QHP-VA InnovationHealth-IVL/. When searching you need to make sure that you are searching for **providers** that participate in your specific policy. When searching for network **dental providers**, you need to make sure you are searching under dental policy. You may call Member Services at the toll-free number on your ID card if you need assistance. Upon request, a copy of the **directory** will be provided to you.

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 your you and your dependents' coverage begins under this policy as noted in our records.

Eligible health services
The health care services and supplies listed in the ***Eligible health services*** *under your policy* section and 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 provided 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 protocol or a written consent form used by a facility **provider** state that it is **experimental or investigational**.
- It is provided or performed in a clinical 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 supportive care to 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 disorder**
- [illegible]cility
- 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.

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** 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 a similar disorder of the jaw joint
- A Myofacial Pain Dysfunction (MPD) of the jaw, or
- 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
An establishment where **prescription drugs** are legally dispensed by mail or other carrier.

Maximum out-of-pocket limit(s)
The maximum out-of-pocket amount for payment of **copayments** and **coinsurance** including any deductible, to be paid by you or any insured dependents per **calendar year** for **eligible health services**.

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

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

Generally accepted standards of medical practice means:

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

You can appeal any determination that a service is not **medically necessary**. Refer to the *When you disagree - claim decisions and appeals procedures* section.

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 ism)
- Psychotic Disorders/Delusional Disorder
- Schizo-afftective Disorder
- Schizophrenia
- Emotional or nervous disorders

This also includes any other mental con on which res **medically necessary** treatment.

Morbid obesity/Morbidly obese

This means the body mass index is well above the nor l range (greater than 40 kilograms per meter squared; or equal to or greater kilograms per me quared) and severe medical conditions may also be present, such as:

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

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

Negoti harge

*As to health coverage, (other than **prescription drug** coverage):*
The maximum amount **network provider** has agreed to accept for rendering services or providing supplies to you or your insured dependent under the policy.

*As to **prescription drug** coverage:*
This only applies to in-network coverage and is the amount we have established for each **prescription drug** obtained from a **network pharmacy** under this policy. This **negotiated charge** may reflect amounts we have 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 we an affiliate, or a third party vendor, 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 (formulary).**

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 policy.

Network provider
A **provider** listed in the **directory** for your policy.

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 (formulary)**.

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

Partial hospitalization treatment
A day or evening treatment program that includes the major diagnostic, medical, psychiatric, and psychosocial rehabilitation treatment modalities to treat a **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.

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 do 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.My.innovationhealth.com/formulary.

Premium
The amount you are required to pay to us to continue 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** Is selected by a person from the list of **PCPs** in the **directory**
- Supervises, coordinates and provides initial care and basic medical services to a person as a family care **physician,** an internist or a pediatrician
- Maintains continuity of patient care
- 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 **substance use disorder,** alcoholism, drug abuse, **mental disorder**, 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:
  - 120% 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)
Is the current average wholesale price of a **prescription drug** listed in the 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 CMS 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 180 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 on to help decide whether to get care in network or out-of-network. Our secure member website at www.My.innovationhealth.com may contain additional information which may help you determine the cost of a service or supply. Log on 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.

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 (CA
  - The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP)
  - The Council on Accreditation (CO

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 is 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**. is onsite 24 hours per day for 7 days a week; and
- The care must be provided under the direct supervision of a **physician**

Retail pharmacy

A community **pharmacy** which has contracted with us, an affiliate, or a third party vendor to provide covered outpatient **prescription drugs** to you.

Room and board

A facility's charge for your overnight **stay** and other services and supplies that are billed 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 two 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 **hospital**s 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 disorder** 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 co-morbidities 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 one of a set of **network pharmacies** 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.My.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 or other types of endoscopy)
- Correction of fracture
- Reduction of dislocation
- Application of plaster casts
- Injection into a joint, 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 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**.

Urgent care facility

A facility licensed as a 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 freestanding health care facility. Includes retail health clinics. These clinics normally operate in major pharmacies or retail stores. Neither of the following should be considered a **walk-in clinic**:

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

Innovation Health Insurance Company

Preferred Provider Organization (PPO)
Medical Plan

Schedule of benefits

Schedule of benefits

This schedule of benefits lists the **deductibles** and **copayments/coinsurance**, if any, that apply to the **eligible health services** you get under this plan. You should read this schedule to become aware of your **deductibles** and **copayments/coinsurance** and any limits that apply to the services.

How to read your schedule of benefits

- You must pay any **deductibles** and **copayments/coinsurance**.
- You must pay the full amount of any health care service you get that is not a **covered benefit**.
- 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
  network providers and **out-of-network providers** unless we say differently.

Important note:
All **covered benefits** are subject to the **calendar year deductible** and **copayment/coinsurance** unless otherwise noted in the schedule of benefits below.

How to contact us for help

We are here to answer any questions.

- Log onto your secure member website at MyInnovationHealth.com.
- Call Member Services at the toll-free number on your ID card.

Innovation Health Insurance Company's policy provides the coverage described in this schedule of benefits**.** This schedule replaces any schedule of benefits previously in use. Keep it with your policy.

Plan features	Cost share/deductible/maximums	
	In-network coverage	**Out-of-network coverage**
Deductible		
You have to meet your **calendar year deductible** before this plan pays for **eligible health services**.		
Individual	$5,050 per **Calendar Year**	$20,000 per **Calendar Year**
Family	$10,100 per **Calendar Year**	$40,000 per **Calendar Year**
Deductible waiver		
The in-network **calendar year deductible** is waived for all of the following **eligible health services:** • Preventive care and wellness • Family planning services - female contraceptives		

Maximum out-of-pocket limit		
Maximum out-of-pocket limit per **calendar year**.		
Individual	$5,050 per **Calendar Year**	none
Family	$10,100 per **Calendar Year**	none

General coverage provisions

This section explains the:

- **Deductible**
- **Maximum out-of-pocket limits**
- Limitations

listed in this schedule of benefits.

Deductible provisions

Your **deductible** may apply to **eligible health services** provided under the medical plan and the outpatient **prescription drug** plan.

Eligible health services applied to the out-of-network **deductible** will not apply to the network **deductible**. **Eligible health services** applied to the network **deductible** will not apply to the out-of-network **deductible**.

The **deductible** may not apply to certain **eligible health services**. You must pay any applicable **copayments/coinsurance** for **eligible health services** to which the **deductible** does not apply.

Individual **deductible**

You pay for network **eligible health services** each **calendar year** before the plan begins to pay. This individual **calendar year deductible** applies separately to you and each covered dependent. Once you have reached the **calendar year deductible**, this plan will begin to pay for **eligible health services** for the rest of the **calendar year**.

Family **deductible**

You pay for network **eligible health services** each **calendar year** before the plan begins to pay. After the amount paid for **eligible health services** reaches your family **calendar year deductible**, this plan will begin to pay for **eligible health services** for the rest of the **calendar year**.

To satisfy this family **deductible** for the rest of the **calendar year**, the following must happen:

- The combined **eligible health services** that you and each of your covered dependents incur towards the individual **calendar year deductibles** must reach this family **deductible** in a **calendar year**.

When this happens in a **calendar year**, the individual **calendar year deductibles** for you and your covered dependents are met for the rest of the **calendar year**.

Copayment: This is a specified dollar amount or percentage that must be paid by you at the time you receive **eligible health services** from a **network provider**.

Coinsurance: The specific percentage you have to pay for a **covered benefit** listed in the schedule of benefits.

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 out-of-network **maximum out-of-pocket limit** will not apply to the network **maximum out-of-pocket limit** and **eligible health services** applied to the network **maximum out-of-pocket limit** will not apply to the out-of-network **maximum out-of-pocket limit**.

The **maximum out-of-pocket limit** is the maximum amount you are responsible to pay for **copayments/coinsurance** and **deductible** for **eligible health services** during the **calendar year**. 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.**

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 **negotiated charge** for **covered benefits** that apply toward the limit for the rest of the **calendar 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 **negotiated charge** for **covered benefits** that apply toward the limit for the remainder of the **calendar year** for all covered family members.

To satisfy this family **maximum out-of-pocket limit** for the rest of the **calendar 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 **calendar year**.

The **maximum out-of-pocket limit** may not apply to certain **eligible health services**. If the **maximum out-of-pocket limit** does not apply to a covered benefit, your **copayment/coinsurance** 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 applied to the out-of-network limit will apply to the network limit and **eligible health services** applied to the network limit will apply to the out-of-network limit.

Your financial responsibility and determination of benefits provisions

Your financial responsibility for the cost of services is based 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 **calendar year**. Determinations regarding when benefits are covered are subject to the terms and conditions of the policy.

Eligible health services	Member cost share In-network coverage	Member cost share Out-of-network coverage
1. Preventive care and wellness		
Preventive care and wellness	0% per visit	50% after **deductible**

- **Routine physical exams-** Performed at a **physician** or **PCP** 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, PCP**, 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 ce visits
- **Routine cancer screenings** - Applies whether performed at a **physician, P** specialist office or facility
- **Prenatal care services**- Provided by an obstetrician (OB), ynecologist (GYN), an or OB/GYN
- **Comprehensive lactation support and counseling servi** - Facility or office visits
- **Breast feeding durable medical equipment** Bre pump plies and accessories
- **Family planning services** – Female contra tive cou ling serv s office visit, devices, voluntary sterilization

Preventive care and wellness benef limitati	
Routine physical exams: Subject to any age and it limits p ided for in the comprehensive guidelines supported by the American Academy f P trics/Brig utures/Health Resources and Services Administration guidelines for children an ado ents. For details, contact your **physician**.	
Preventive care immunizations: to any ge lim rovided for in the comprehensive guidelines supported by Advisory Com ittee unization Practices of the Centers for Disease Control and Prevention. For details, cont t your **phy cian**.	
Well woman preventi visits - routine g necological exams (including pap smears): Subject to any age limits ov d for in the co rehensive guidelines supported by the Health Resources and Services Administra	
Preventive s reening and co nseling ervices: Limitations are per **calendar year** unless stated below:	
Obesity nd/or healthy diet	Age 0-22, unlimited visits; age 22+, 26 visits every 12 months, of which up to 10 visits may be used for healthy diet counseling
Misuse of alcohol and/or d ugs	Limited to 5 visits every 12 months
Use of tobacco pr ducts	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

Any lung cancer screenings that exceed the cancer screening limit are covered under the *Outpatient diagnostic testing* section.

Comprehensive lactation support and counseling services:

- Lactation counseling services maximum visits every 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
- Limited to 6 visits

Breast feeding durable medical equipment: Review the *Maternity and related newborn care* sections. They will give you more information on coverage levels for maternity care under this plan. See the *Breast feeding durable medical equipment* section of the policy for limitations on breast pump and supplies.

Family planning services:

- Contraceptive counseling services maximum visits every 12 months in either a group or individual setting
- Limited to 2 visits

Eligible health services	Member cost share In-network coverage	Member cost share Out-of-network coverage
2. Physicians and other health professionals		
Physician services		
Office hours visits (non-surgical) non preventive care	$5 **copay,** no **deductible** applies	50% after **deductible**
Telemedicine consultation by a **physician** or **PCP**	$0, no **deductible** applies	50% after **deductible**
Specialist office visits		
Office hours visits (non-surgical)	0% after **deductible**	50% after **deductible**
Telemedicine consultation by a **specialist**	$0, no **deductible** applies	50% after **deductible**
Allergy injections		
Without a physician, PCP or specialist office visit	Covered based on type of service and where it is received	50% after **deductible**
Allergy testing and treatment		
Performed at a **physician, PCP** 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, PCP** or **specialist** office	Covered based on type of service and where it is received	50% after **deductible**
Physician surgical services		
Performed at a **physician**, **PCP** 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	$5 **copay,** no **deductible** applies	50% after **deductible**
Preventive care immunizations	$0 per visit	50% after **deductible**
Individual screening and counseling services at a walk-in clinic Includes obesity and/or healthy diet counseling, use of tobacco products services		
Individual screening and counseling services	$0 per visit	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	Member cost share In-network coverage	Member cost share 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	0% after **deductible**	50% after **deductible**
Performed in facility other than **hospital** outpatient department	0% after **deductible**	50% after **deductible**
Home health care		
Outpatient	0% after **deductible**	50% after **deductible**
Visit limit per calendar year	None	None
Hospice care		
Inpatient services	0% after **deductible**	0% after **deductible**
Outpatient services	0% after **deductible**	0% after **deductible**
Skilled nursing facility		
Inpatient facility	0% after **deductible**	0% after **deductible**
Day limit per calendar year	None	None
Private duty nursing		
Outpatient private duty nursing	0% after **deductible**	50% after **deductible**
Limit	Coverage is limited to 16 hours per **calendar year.**	Coverage is limited to 16 hours per **calendar year.**

Eligible health services	Member cost share In-network coverage	Member cost share 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	0% after **deductible**	Paid the same as in-network coverage
Non-emergency care in a **hospital** emergency room (limited to initial screening and stabilization)	Paid the same as **hospital** emergency room	Paid the same as in-network coverage
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.		
Urgent medical care at a free standing facility that is not a hospital	$5 **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	Member cost share In-network coverage	Member cost share 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% per visit	30% after **deductible**
Type B services	0% after **deductible**	50% after **deductible**
Type C services	0% after **deductible**	50% after **deductible**
Orthodontic services	0% after **deductible**	50% after **deductible**
Dental benefits are subject to the medical plan's **deductibles** and **maximum out-of-pocket limits** as explained on the 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 6 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)
- Hospital call
- Topical application of fluoride(limited to 2 courses of treatment per year)
- Sealants, per tooth (limited to one application every 3 years for permanent molars only)
- Bitewing images/x-rays
- Periapical images/x-rays (single image up to 13)
- Complete image series, including bitewings **medically necessary** or panoramic radiographic image (limited to 1 set every 3 years)
- Vertical bitewing images/x-rays
- Cephalometric radiographic image

Intra-oral, occlusal radiographic image
Diagnostic casts
Space maintainers

- Space maintainer (includes all adjustments within 6 months after installation)
- Fixed (unilateral or bilateral)
- Removable (unilateral or bilateral)
- Recementation of space maintainer
- Removal of fixed space maintainer (by other than the dentist or office that placed it)

Basic restorative care (type B services)
Visits

- 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

Other Expenses

- Therapeutic drug injections
- Therapeutic parental drugs
- Application of desensitive medication

Images and pathology

- Extra-oral
- 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 extraction - 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
  - Removal of cysts, tumors, and growths
  - Incision and drainage of abscess, soft tissue
  - 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
  - Surgical exposure to aid eruption
  - Frenulectomy/Frenuloplasty

Periodontics

- Occlusal adjustment (other than with an appliance or by restoration)
- Periodontal scaling and root planing, 4 or more teeth per quadrant (limited to 4 separate quadrants every 2 years
- Periodontal scaling and root planing, 1-3 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
- Pulp therapy/ anterior and posterior primary tooth
- Apexification/pulpal regeneration
- Apexification/recalcification
- Apicoectomy/periadiculary surgery, anterior, bicuspid, molar
- Retrograde filing
- Root canal therapy including **medically necessary** images/x-rays:
  - Anterior
  - Bicuspid
- Retreatment of previous root canal therapy including images:
  - 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)
- Pins
  - 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
- Recementation
  - Inlay
  - Crown
  - Bridge

Major restorative care (type C services)

Oral Surgery

- Surgical removal of impacted teeth
  - Removal of tooth (partially bony)
  - Removal of tooth (completely bony)

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), 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, molar

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 (limited to 1 per tooth every 5 years)
- Inlays/onlays (limited to 1 per tooth every 5 years)
- Crowns
  - Resin (limited to 1 per tooth every 5 years)
  - Resin with high noble metal (limited to 1 per tooth every 5 years)
  - Resin with noble metal (limited to 1 per tooth every 5 years)
  - Resin with base metal (limited to 1 per tooth every 5 years)
  - Porcelain/ceramic substrate (limited to 1 per tooth every 5 years)
  - Porcelain fused to high noble metal (limited to 1 per tooth every 5 years)
  - Porcelain fused to noble metal (limited to 1 per tooth every 5 years)
  - Porcelain fused to base metal (limited to 1 per tooth every 5 years)
  - High noble (full cast) (limited to 1 per tooth every 5 years)
  - Base metal (full cast) (limited to 1 per tooth every 5 years)
  - Noble metal (full cast) (limited to 1 per tooth every 5 years)
  - 3/4 cast metallic or porcelain/ceramic (limited to 1 per tooth every 5 years)
  - Titanium (limited to 1 per tooth every 5 years)
  - Retainer crown (limited to 1 per tooth every 5 years)
  - Post and core
  - Core build-up
  - Temporary crowns

Prosthodontics

- Replacement of existing bridges or dentures is limited to 1 every 5 years
- Bridge abutments (limited to 1 every 5 years)- See Inlays and Crowns
- 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 every 5 years)
  - Porcelain with base metal (limited to 1 per tooth every 5 years)
  - Resin with noble metal (limited to 1 per tooth every 5 years)
  - Resin with base metal (limited to 1 per tooth 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)
- Complete lower denture (limited to 1 every 5 years)
- Immediate upper denture/ immediate upper partial denture (limited to 1 every 5 years)
- Immediate lower denture/ immediate lower partial denture (limited to 1 every 5 years)
- Partial upper or lower, resin base including any conventional clasps, rests and teeth (limited to 1 every 5 years)
- Partial upper or lower, cast metal base with resin saddles including any conventional clasps, rests and teeth (limited to 1 every 5 years)
- 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
  - 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

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 (limit one per lifetime)

Eligible health services	Member cost share In-network coverage	Member cost share 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	Not covered	Not covered
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**
Voluntary termination of pregnancy	Not covered	Not covered
Outpatient services		
Voluntary sterilization for males	Covered based on the type of service and where it is received	50% after **deductible**
Voluntary termination of pregnancy	Not covered	Not covered
Jaw joint disorder treatment		
Jaw joint disorder treatment	Covered based on type of service and where it is received	Covered based on type of service and where it is received

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 **copayment/coinsurance** that is collected applies to the delivery and postpartum care services provided by an OB, GYN, or OB/GYN only. No **copayment/coinsurance** that is collected applies to prenatal care services provided by an OB's, 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** or skilled behavioral health services in the home, **partial hospitalization treatment** and **intensive outpatient program**	0% after **deductible**	50% after **deductible**
Other outpatient mental health treatment	% after **deductible**	50% after **deductible**

Substance use disorder treatment Coverage provided under the same terms, conditions as any other **illness**.		
Inpatient **detoxification** Inpatient rehabilitation Inpatient treatment in **residential treatment facility**	0% after **deductible**	50% after **deductible**
Other inpatient **detoxification** services and supplies Other inpatient rehabilitation services and supplies Other inpatient **residential treatment facility** services and supplies	0% after **deductible**	50% after **deductible**
Outpatient visits to a **physician** or **behavioral health provider** including **partial hospitalization treatment** and **intensive outpatient program**	0% after **deductible**	50% after **deductible**
Other outpatient services	0% after **deductible**	50% after **deductible**
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	**Member cost share Network (IOE facility)**	**Member cost share Out-of-network (Non-IOE facility)**

Transplant services facility and non-facility		
Inpatient and other inpatient services and supplies	0% after **deductible**	50% after **deductible**
Outpatient	0% after **deductible**	50% after **deductible**
Physician services	0% after **deductible**	50% after **deductible**
Eligible health services	**Member cost share In-network coverage**	**Member cost share 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	**Member cost share In-network coverage**	**Member cost share Out-of-network coverage**
7. Specific therapies and tests		
Outpatient diagnostic testing		
Diagnostic complex imaging services		
Performed at a facility	0% after **deductible**	50% after **deductible**
Performed at physician, PCP office	0% after **deductible**	50% after **deductible**
Performed at specialist office	0% after **deductible**	50% after **deductible**
Diagnostic lab work		
Performed at a facility	**Copay,** no **deductible** applies	50% after **deductible**
Performed at physician, PCP office	Included in OV **Copay**	50% after **deductible**
Performed at specialist office	0% after **deductible**	50% after **deductible**
Diagnostic imaging services		
X-ray		
Performed at a facility	0% after **deductible**	50% after **deductible**
Performed at **physician**, **PCP** office	Included in OV **Copay**	50% after **deductible**
Performed at **specialist** office	0% after **deductible**	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	Covered based on type of service and where it is received	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, the outpatient department of a **hospital**, 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	0% after **deductible**	50% after **deductible**
Rehabilitation therapy services A visit is equal to no more than 1 hour of therapy.		
Outpatient physical therapy		
Physical therapy	0% after **deductible**	50% after **deductible**
Visit limit per **calendar year**	None	None
Outpatient occupational therapy		
Occupational therapy	0% after **deductible**	50% after **deductible**
Visit limit per **calendar year**	None	None
Outpatient speech therapy		
Speech therapy	0% after **deductible**	50% after **deductible**
Visit limit per **calendar** year	None	None

Spinal manipulation		
Spinal manipulation	0% after **deductible**	50% after **deductible**
Visit limit per **calendar year**	Coverage is limited to 30 visits per **calendar year** for rehabilitation **services** and 30 visits per **calendar year** for habilitation **services** network and out-of-network combined	Coverage is limited to 30 visits per **calendar year** for rehabilitation **services** and 30 visits per **calendar year** for habilitation **services** 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	0% after **deductible**	50% after **deductible**
Visit limit per **calendar year**	None	None

Eligible health services	**Member cost share In-network coverage**	**Member cost share 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**	Not covered	Not covered
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	0% after **deductible**	50% after **deductible**
Limit per **calendar year**	None	None
Nutritional supplements		
Nutritional supplements	0% after **deductible**	50% after **deductible**
Prosthetic devices		
Prosthetic devices	0% after **deductible**	50% after **deductible**

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	$0, no **deductible** applies	50% after **deductible**
Visit limit per **calendar year**	Coverage is limited to 1 exam every 12 months age 0-19 network and out-of-network combined	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
Preferred or non-preferred eyeglass frames, **prescription** lenses or **prescription** contact lenses	$0, no **deductible** applies	50% after **deductible**
Number of eyeglass frames per **calendar year**	One set of eyeglass frames	
Number of **prescription** lenses per **calendar year**	One pair of **prescription** lenses	
Number of **prescription** contact lenses per **calendar year** (includes non-conventional **prescription** contact lenses and lenses prescribed after cataract surgery)	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	Not covered	Not covered
Visit limit per **calendar year**	None	None
Vision care services and supplies		
Eyeglass frames, **prescription** lenses or **prescription** contact lenses	Not covered	Not covered
Non-conventional **prescription** contact lenses and aphakic lenses prescribed after cataract 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
Number of **prescription** contact lenses per **calendar year** (includes non-conventional **prescription** contact lenses and aphakic lenses prescribed after cataract surgery)	Daily disposables: up to 3 month supply Extended wear disposable: up to 6 month supply Non-disposable lenses: one set	
Limit per **calendar year** eyeglass frames, **prescription** lenses or **prescription** contact lenses	None	None
Important note: Refer to the *Vision care* section in the policy for the explanation of these vision care supplies. As to coverage for **prescription** lenses in a **calendar year**, this benefit will cover either **prescription** lenses for eyeglass frames or **prescription** contact lenses, but not both.		

Eligible health services	Member cost share In-network coverage	Member cost share Out-of-network coverage
9. Outpatient prescription drugs		
Waiver for risk reducing breast cancer prescription drugs		
The **calendar year prescription drug** cost share will not apply to risk reducing breast cancer **prescription drugs** when obtained at a **network pharmacy**. This means that such risk reducing breast cancer **prescription drugs** 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 that such contraceptive methods 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 **brand name prescription drugs** that have a generic equivalent, 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** will be covered.		
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 regimens for tobacco cessation **prescription drugs** and OTC drugs when obtained at a **retail network pharmacy**. This means that such **prescription drugs** and OTC drugs will be paid at 100%. Your **prescription drug** cost share will apply after those two regimens have been exhausted.		

Eligible health services	Member cost share In-network coverage	Member cost share Out-of-network coverage
Per prescription copayment/coinsurance		
Tier 1 -- generic prescription drugs		
For each 30 day supply filled at a **retail pharmacy** (**specialty prescription drugs** are not eligible for a 30 day supply filled at a **retail pharmacy**)	$5 **copay,** no **deductible** applies	50% after **deductible**
For all fills greater than a 30 day supply but no more than a 90 day supply filled at a **retail pharmacy** or **mail order pharmacy** (**specialty prescription drugs** are not eligible for a 90 day supply filled at a **mail order pharmacy**)	$10 **copay,** no **deductible** applies	50% after **deductible**
Tier 2 -- preferred brand-name [illegible]ription drugs		
For each fill up to a 30 day supply filled at a **retail pharmacy** (**specialty prescription drugs** are not eligible for a 30 day sup[illegible] filled at a **retail [illegible]armacy**)	0% after **deducti[illegible]**	50% after **deductible**
For all fi[illegible] greater th[illegible] 30 day supp[illegible] but no more than a 90 day supply filled at a **retail [illegible] pharmacy** or **mail order pharmacy** (**specialty prescription drugs** are not eligible for a 90 day supply filled at a **mail order pharmacy**)	0% after **deductible**	50% after **deductible**

Tier 3 -- non-preferred brand-name prescription drugs		
For each 30 day supply filled at a **retail pharmacy** (**specialty prescription drugs** are not eligible for a 30 day supply filled at a **retail pharmacy**)	0% after **deductible**	50% after **deductible**
For all fills greater than a 30 day supply but no more than a 90 day supply filled at a **retail pharmacy** or **mail order pharmacy** (**specialty prescription drugs** are not eligible for a 90 day supply filled at a **mail order pharmacy**)	0% after **deductible**	50% after **deductible**
Tier 4 -- specialty prescription drugs (including biosimilar prescription drugs)		
For each 30 day supply filled at a specialty **network pharmacy**	0% after **deductible**	Not covered
Diabetic supplies and insulin		
For each 30 day supply filled at a **retail pharmacy**	Paid according to the tier of drug per the schedule of benefits, above	Paid according to the tier of drug per 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 pharmacy** or **mail order pharmacy**	Paid according to the tier of drug per the schedule of benefits, above	Paid according to the tier of drug per 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 per the schedule of benefits, above	Paid according to the tier of drug per 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**	$0 per **prescription** or refill	50% after **deductible**

prescription drugs. For each 30 day supply Brand-name vaginal rings covered at 100% to the extent that a generic is not available		
Female contraceptives that are **brand-name prescription drugs.** For each 30 day supply Brand-name vaginal rings covered at 100% to the extent that a generic is not available	Paid according to the tier of drug per the schedule of benefits, above	Paid according to the tier of drug per the schedule of benefits, above
Female contraceptive **generic** devices and **brand-name** devices. For each 30 day supply	Paid according to the tier of drug per the schedule of benefits, above	Paid according to the tier of drug per 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 per the schedule of benefits, above	Paid according to the tier of drug per 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 per the schedule of benefits, above	Paid according to the tier of drug per 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 per 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 per 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 per the schedule of benefits, above
Limitations: • Coverage is permitted for two, 90-day treatment regimens only. Any additional treatment regimens will be paid according to the tier of drug per the schedule of benefits, above. • Coverage only includes generic drug when a brand-name drug is available. • 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 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 sharing that applies to **brand-name prescription drugs**.		