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# HEALTH MAINTENANCE ORGANIZATION (HMO)

## SCHEDULE OF BENEFITS

## Imperial Preferred Silver Limited CSR



IMPERIAL INSURANCE COMPANIES

# SCHEDULE OF BENEFITS

This Schedule of Benefits lists the **deductibles**, **copayments** if any, which apply to the **eligible health services you** get under this plan. **You** should read this schedule to become aware of these and any limits that apply to the services.

### How To Read Your Schedule of Benefits

- **You** must pay any **deductibles**, **copayments** if they apply.
- **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 limits
  - Day limits
  - Dollar limits

### IMPORTANT NOTE:

All **covered benefits** are subject to the **calendar year deductible**, **maximum out-of-pocket limit**, **copayments** or **coinsurance** unless otherwise noted in this Schedule of Benefits below.

### How Your Deductible Works

This Schedule of Benefits shows the **deductible** amounts that apply to **your** plan. Once **you** have met **your deductible**, **we** will start sharing the cost when **you** get **eligible health services**. **Copayments** do not accumulate to **your deductible,** but do accumulate to **your maximum out-of-pocket limit**. **You** will continue to pay **copayments** or **coinsurance**, if any, for **eligible health services** after **you** meet **your deductible**.

### How Your PCP Or Physician Office Visit Cost Share Works

**You** will pay the **PCP** cost share when **you** get **eligible health services** from the **PCP you** select. **You** will pay the **specialist** cost share when **you** get **eligible health services** from a network **PCP** that is not **your PCP**. If **you** did not select a **PCP you** will pay the **specialist** cost share for **eligible health services** from any network **PCP** or network **specialist**.

### How Your Maximum Out-Of-Pocket Limit Works

This Schedule of Benefits shows the **maximum out-of-pocket limits** that apply to **your** plan. Once **you** reach **your maximum out-of-pocket limit**, **your** plan will pay for **eligible health services** for the remainder of that year.

## How To Contact Us For Help

**We** are here to answer **your** questions. **You** can:

- Go to our website at **www.ImperialHealthPlan.com**
- Call the number on **your** ID card

Imperial Insurance Companies HMO **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**.



IMPERIAL INSURANCE COMPANIES

## Plan Features –Deductible And Maximum Out-Of-Pocket Limits

### Deductible

**You** Have To Meet **Your Deductible** Before This Plan Pays For Benefits.

| Deductible | In-Network |
|---|---|
| Individual | $6,500 |
| Family | $13,000 |

### Deductible Waiver

The in-network **deductible** is waived for all of the following **eligible health services**:

- Preventive care and wellness
- Family planning services – female contraceptives
- Nutritional Support

### Maximum Out-Of-Pocket Limit

| Maximum Out-Of-Pocket Limit | In-Network |
|---|---|
| Individual | $10,500 |
| Family | $21,000 |

## General Coverage Provisions

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

### Deductible Provisions

- **Your deductible** may apply to **eligible health services** provided under the medical plan and the outpatient **prescription drug** plan.
- The **deductible** may not apply to certain **eligible health services**. **You** must pay any applicable cost share for **eligible health services** to which the **deductible** doesn't apply.

### Individual Deductible

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

### Family Deductible

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

To satisfy this family **deductible** for the rest of the year, the combined **eligible health services** that **you** and each of **your** covered dependents incur towards the individual **deductible** must reach this family **deductible** in a year.

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

### Deductible Credit

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

### Maximum Out-Of-Pocket Limit 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.
- This plan may have an individual and family **maximum out-of-pocket limit**. As to the individual **maximum out-of-pocket limit**, each of **you** must meet **your maximum out-of-pocket limit** separately.

### Individual Maximum Out-Of-Pocket Limit

Once **you** or **your** covered dependents meet the individual **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered benefits** that apply toward the limit for the rest of the year for that person.

### Family Maximum Out-Of-Pocket Limit

Once **you** or **your** covered dependents meet the family **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered benefits** that apply toward the limit for the remainder of the year for all covered family members.

To satisfy this family **maximum out-of-pocket limit** for the rest of the year, the following must happen:

- The family **maximum out-of-pocket limit** is a cumulative **maximum out-of-pocket limit** for all family members
- The family **maximum out-of-pocket limit** is met by a combination of family members
- No one person within a family will contribute more than the individual **maximum out-of-pocket limit** amount in a year

If the **maximum out-of-pocket limit** does not apply to a **covered benefit**, **your** cost share for that **covered benefit** will not count toward satisfying the **maximum out-of-pocket limit** amount. Certain costs that **you** incur do not apply toward the **maximum out-of-pocket limit**. These include:

- All costs for non-covered services
- Any out of pocket costs for non-emergency use of the emergency room
- Any out of pocket costs incurred for non-urgent use of an urgent care **provider**
- Amounts received from a third-party **copay** assistance program, like a manufacturer coupon or rebate, for a **specialty prescription drug**

### Your Financial Responsibility And Decisions Regarding Benefits

**We** base **your** financial responsibility for the cost of services on when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment or portions of **stays** that occur in more than one year. Decisions regarding when benefits are covered are subject to the terms and conditions of the **Policy**.

## Eligible Health Services

## 1. Preventive Care And Wellness

| Description | In-Network |
|---|---|
| Preventive care and wellness | $0 **copay**, no **deductible** applies |

Preventive Care And Wellness includes:

- Routine physical exams performed at a **physician** office
- Preventive care immunizations performed at a facility or at a **physician** office
- Well woman preventive visits including routine gynecological exams and Pap smears) performed at a **physician**, obstetrician (OB), gynecologist (GYN) or OB/GYN office
- Preventive screening and counseling services which includes obesity and/or healthy diet counseling, misuse of alcohol and/or drugs, use of tobacco products, sexually transmitted infection counseling, genetic risk counseling for breast and ovarian cancer - office visits
- Routine cancer screenings performed at a **physician**, **specialist** office or facility
- Prenatal care services - provided by an OB, GYN, or OB/GYN
- Comprehensive lactation support and counseling services - facility or office visits
- Breast feeding durable medical equipment - breast pump supplies and accessories
- Family planning services – female contraceptive counseling services office visit, devices, voluntary sterilization

### Preventive Care And Wellness Benefit Limits

**Routine Physical Exams**

- Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents
- High risk Human Papillomavirus Virus (HPV) DNA testing

### Preventive Care Immunizations

Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact **your physician.**

### Well Woman Preventive Visits

Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

**Preventive Screening And Counseling Services**

- Obesity and/or healthy diet
- Misuse of alcohol and/or drugs
- Use of tobacco products
- Sexually transmitted infection
- Genetic risk counseling for breast and ovarian cancer

### Routine Cancer Screenings

Subject to any age; family history; and frequency guidelines as set forth in the most current:

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

Lung cancer screenings that exceed the cancer-screening limit are covered under the *Outpatient Diagnostic Testing* section.

### Prenatal Care Services

Review the *Maternity and Related Newborn Care* section of **your Policy**. It will give **you** more information on coverage levels for maternity care under this plan.

### Comprehensive Lactation Support And Counseling Services

- Lactation counseling services either in a group or individual setting
- Lactation counseling services are covered under this benefit for the duration of the member's needs for counseling and support

### Breast Feeding Durable Medical Equipment

See the *Breast Feeding Durable Medical Equipment* section of the **Policy** for limitations on breast pump and supplies.

### Family Planning Services

Contraceptive counseling services limited to 2 visits per 12 months in either a group or individual setting

## 2. Physicians And Other Health Professionals

### Physician Services/Primary Care Physician (PCP) Visit

| Description | In-Network |
|---|---|
| PCP Office hours visits (non-surgical)<br>non preventive care | $10 **copay**, no **deductible** applies |
| **Telemedicine** or **telehealth** consultation by a **Physician** | $0 **copay**, no **deductible** applies |
| Other Practitioner Office Visit | $10 **copay**, no **deductible** applies |

**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** get **your** care from:
  - **Your PCP**
  - Another **network provider** after **you** get a **referra**l from **your PCP**
- **You** or **your provider preauthorizes** the **eligible health service** when required

**Specialist Office Visits**

| Description | In-Network |
|---|---|
| Office hours visit (non-surgical) | $20 **copay**, no **deductible** applies |
| **Telemedicine** or **telehealth** consultation by a **Specialist** | $20 **copay**, no **deductible** applies |

**Allergy Testing And Treatment**

| Description | In-Network |
|---|---|
| Performed at a **physician** or **specialist** office visit | 40.00% **Coinsurance** after **deductible** |

**Immunizations That Are Not Considered Preventive Care**

| Description | In-Network |
|---|---|
| Immunizations that are not considered preventive care | 40% **coinsurance** after **deductible** |

**Medical Injectables**

| Description | In-Network |
|---|---|
| Performed at a **physician** or **specialist** office | 40% **coinsurance** after **deductible** |

**Physician Surgical Services**

| Description | In-Network |
|---|---|
| Inpatient surgical services | 40.00% **Coinsurance** after **deductible** |
| Performed at a **physician** or **specialist** office | 40.00% **Coinsurance** after **deductible** |

## 3. Inpatient and Outpatient Hospital Services

**Hospital Care**

| Description | In-Network |
|---|---|
| Inpatient **hospital** | 40.00% **Coinsurance** after **deductible** |

**Private-Duty Nursing**

| Description | In-Network |
|---|---|
| Private-Duty Nursing | 40% **coinsurance** after **deductible** |
| Limits | When provided by a Hospital, Ambulatory Surgical Facility, Skilled Nursing Facility, or Hospice Care Facility, limits for such facility services apply |

**Specialty Prescription Drugs**

| Description | In-Network |
|---|---|
| Performed in a **physician** office, outpatient department of a **hospital**, other outpatient facility that is not a **hospital**, or in the home | 40% **coinsurance** after **deductible** |

## 4. Extended Care Services

### Outpatient Surgery

| Description | In-Network |
|---|---|
| Physician/Surgical services performed in **hospital** outpatient department or other facility | 40.00% **Coinsurance** after **deductible** |
| Outpatient Facility Fee (e.g., Ambulatory Surgical Center) | 40.00% **Coinsurance** after **deductible** |

### Home Health Care

| Description | In-Network |
|---|---|
| Outpatient | 40.00% **Coinsurance** after **deductible** |
| Visit limit per year | Unlimited except for 1 social service consultation and 1 nutrition consultation |

**IMPORTANT NOTE:**
Limited to 3 intermittent visits per day provided by a participating home health care agency. 1 visit equals a period of 4 hours or less. Intermittent visits are periodic and recurring visits that skilled nurses make to ensure your proper care. The intermittent requirement may be waived to allow coverage for up to 12 hours with a daily maximum of 3 visits. Services must be provided within 10 days of discharge.

### Hospice Care

| Description | In-Network |
|---|---|
| Inpatient services | 40.00% **Coinsurance** after **deductible** |
| Outpatient services | 40.00% **Coinsurance** after **deductible** |
| Respite Care Limit | 5 Inpatient days or 5 Outpatient visits per 90 days |

### Skilled Nursing Facility

| Description | In-Network |
|---|---|
| Inpatient facility | 40.00% **Coinsurance** after **deductible** |
| Day limit per year | Coverage is limited to 100 days per calendar year |

## 5. Emergency Services

A Separate **Hospital** Emergency Room (Or Comparable Facility/Freestanding Emergency Medical Care Facility) Or Urgent Care Cost Share Will Apply For Each Visit To An Emergency Room Or An Urgent Care **Provider**.

| Description | In-Network |
|---|---|
| **Hospital** emergency room (or comparable facility/freestanding emergency medical care facility) | 40.00% **Coinsurance** after **deductible** |
| Non-emergency care in a **hospital** emergency room (or comparable facility/freestanding emergency medical care facility) | Not covered |

**IMPORTANT NOTE:**

Emergency Services are **covered the same out-of-network as in-network. Out-of-network providers** do not have a contract with **us**. **We** will pay the **provider** at **our** usual and customary rate or at an agreed rate charge. The **provider** may not accept payment of **your** cost share (**deductible**, **copayment**) 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. **You** should send the bill to the address listed on the back of your ID card, and **we** will resolve any payment dispute with the **provider** over that amount. Make sure the member's ID number is on the bill. If **you** are admitted to a **hospital** as an inpatient right after a visit to an emergency room (or comparable facility/freestanding emergency medical care facility) and **you** have an emergency room **copay**, **your copay** will be waived.

## 6. Urgent Care Services

| Description | In-Network |
|---|---|
| Urgent medical care at a free standing facility that is not a **hospital** | $60 **copay**, no **deductible** applies |

## 7. Pregnancy and Maternity Care

### Family Planning Services - Other

**Voluntary Sterilization for Males**

| Description | In-Network |
|---|---|
| Inpatient | 40% **coinsurance** after **deductible** |
| Outpatient | 40% **coinsurance** after **deductible** |

### Maternity And Related Newborn Care

**Inpatient Prenatal and Postnatal Care Services**

| Description | In-Network |
|---|---|
| Inpatient maternity and prenatal related services and supplies | $10 **copay**, no **deductible** applies |

**Delivery and Maternity Care Services**

| Description | In-Network |
|---|---|
| Inpatient and newborn care services and supplies | 40.00% **Coinsurance** after **deductible** |
| Well Baby Visits and Care | $0 **copay** no **deductible** applies |

**IMPORTANT NOTE:**

When **you** receive services from an OB, GYN or OB/GYN for prenatal care, **you** will not incur a cost share. However, **you** will incur a cost share for delivery and postpartum care services received by an OB, GYN or OB/GYN.

## 8. Pediatric

### 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)

| Description | In-Network |
|---|---|
| Performed by an ophthalmologist or optometrist | 0% **coinsurance**, no **deductible** applies |
| Visit limit per year | Coverage is limited to 1 exam every 12 months |

**Pediatric Vision Care Services And Supplies**

Coverage is limited to covered persons through the end of the month in which the person turns 19

| Description | In-Network |
|---|---|
| Office visit for fitting of contact lenses | Not covered |
| Eyeglass frames, **prescription** lenses or **prescription** contact lenses | 0% **coinsurance**, no **deductible** applies |

**Limits**

| Description | Limit |
|---|---|
| Number of eyeglass frames per year | One set of eyeglass frames |
| Number of **prescription** lenses per year | One pair of **prescription** lenses |
| Number of **prescription** contact lenses per year | Daily disposables: up to 3 month supply<br>Extended wear disposable: up to 6 month supply<br>Non-disposable lenses: one set |

**IMPORTANT NOTE:**

Refer to the *Pediatric Vision Care* section in the **Policy** for the explanation of these vision care supplies. As to coverage for **prescription** lenses in a year, this benefit will cover either **prescription** lenses for eyeglass frames or **prescription** contact lenses, but not both**.**

### Pediatric Dental Care

Coverage is limited to covered persons through the end of the month in which the person turns 19

| Description | In-Network |
|---|---|
| Diagnostic and Preventive Services | 0% **coinsurance**, no **deductible** applies |
| Basic Services | 40% **coinsurance**, no **deductible** applies |
| Major Services | 40.00% **Coinsurance** after **deductible** |
| Medically Necessary Orthodontic Services | 40.00% **Coinsurance** after **deductible** |

## 9. Specific Therapies and Tests

### Outpatient Diagnostic Testing

| Description | In-Network |
|---|---|
| Diagnostic Complex Imaging Services | 40.00% **Coinsurance** after **deductible** |
| Diagnostic Lab Work | $40 **copay**, no **deductible** applies |
| Diagnostic Radiological Services (x-rays) | $140 **copay**, no **deductible** applies |

**IMPORTANT NOTE:**

Cost shares for diagnostic mammograms will be considered the same as mammograms performed for routine cancer screenings as described in the *Preventive Care And Wellness* section. Diagnostic mammograms are not subject to any age limitation.

**IMPORTANT NOTE:**

Even if **you** receive **eligible health services** at a health care facility that is a **network provider**, not all services may be in network. Other services **you** receive may be from a **physician** or facility that is an **out-of-network provider**. **Providers** that may not be **network providers** include anesthesiologists, radiologists, pathologists, neonatologists, emergency room physicians and assistant surgeons. **You** may receive a bill for services from these **out-of-network providers**, as **we** paid them at **our** usual and customary rate or at an agreed rate. **We** will work with the **providers** so that all **you** pay is your appropriate network level **copayments**. If **you** are in receipt of a balance bill for covered services from any physician or **provider**, including a facility-based physician or other health care practitioner please contact **us.**

## Outpatient Therapies

**Chemotherapy**

| Description | In-Network |
|---|---|
| Chemotherapy | 40.00% **Coinsurance** after **deductible** |

**Outpatient Infusion Therapy**

| Description | In-Network |
|---|---|
| Performed in a **physician** office, person's home, outpatient facility, or outpatient department of a hospital | 40.00% **Coinsurance** after **deductible** |

**Radiation Therapy (Therapeutic Radiology)**

| Description | In-Network |
|---|---|
| Radiation therapy | 40.00% **Coinsurance** after **deductible** |

## Short-Term Cardiac And Pulmonary Rehabilitation Services

A visit is equal to no more than 1 hour of therapy.

| Description | In-Network |
|---|---|
| Cardiac and pulmonary rehabilitation | 40.00% **Coinsurance** after **deductible** |
| Limit | Unlimited |

## Short-Term Rehabilitation Therapy Services

A visit is equal to no more than 1 hour of therapy.

**Outpatient Physical Therapy**

| Description | In-Network |
|---|---|
| Physical Therapy (PT) | $40 **copay**, no **deductible** applies |
| Visit limit per year | Coverage for Outpatient Physical, Occupational, and Speech therapy is limited to a combined 120 visits per calendar year |

**Outpatient Occupational Therapy**

| Description | In-Network |
|---|---|
| Occupational Therapy (OT) | $40 **copay**, no **deductible** applies |
| Visit limit per year | Coverage for Outpatient Physical, Occupational, and Speech therapy is limited to a combined 120 visits per calendar year |

**Outpatient Speech Therapy**

| Description | In-Network |
|---|---|
| Speech Therapy (ST) | $40 **copay**, no **deductible** applies |
| Visit limit per year | Coverage for Outpatient Physical, Occupational, and Speech therapy is limited to a combined 120 visits per calendar year |

**Chiropractic**

| Description | In-Network |
|---|---|
| Spinal manipulation (Chiro) | $40 **copay**, no **deductible** applies |
| Visit limit per year | Coverage is limited to 20 visits per calendar year |

**Habilitation Therapy Services**

| Description | In-Network |
|---|---|
| Physical, occupational, and speech therapies | 40.00% **Coinsurance** after **deductible** |
| Visit limit per year | Coverage is limited to 120 visits per calendar year |

## 10. Other Services and Conditions

**Ambulance Service**

| Description | In-Network |
|---|---|
| Emergency **ambulance** | 40.00% **Coinsurance** after **deductible** |
| Non-emergency **ambulance** | 40.00% **Coinsurance** after **deductible** |

**IMPORTANT NOTE:**

- **Out-of-network providers** do not have a contract with **us**. **We** will pay the **provider** at **our** usual and customary rate or at an agreed rate charge. The **provider** may not accept payment of **your** cost share (**copayment**), 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.
- **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.

**Clinical Trial Therapies (Experimental Or Investigational)**

| Description | In-Network |
|---|---|
| Clinical trial therapies (including routine patient costs) | 40% **coinsurance** after **deductible** |

**Durable Medical Equipment (DME)**

| Description | In-Network |
|---|---|
| **DME** | 40.00% **Coinsurance** after **deductible** |
| Limit | Single purchase of a type of DME every 3 years |

**Hearing Aids and Cochlear Implants and Related Services**

| Description | In-Network |
|---|---|
| Hearing aids | 40.00% **Coinsurance** after **deductible** |
| Hearing aids limit | Single purchase of a type of Hearing Aid every 3 years |
| Cochlear implants and related services | 40.00% **Coinsurance** after **deductible** |
| Replacement of cochlear implant external speech processor and controller components limit | Single purchase of a type of Hearing Aid every 3 years |

**Nutritional Support**

| Description | In-Network |
|---|---|
| Nutritional support | 40% **coinsurance** after **deductible** |
| Limits | Special Food Products and Enteral Formulas subject to limit of 30 day supply 4 times per year |

**Biomarker Testing**

| Description | In-Network |
|---|---|
| Biomarker Testing | 40.00% **Coinsurance** after **deductible** |

**Obesity (Bariatric) Surgery**

| Description | In-Network |
|---|---|
| Obesity (bariatric) **surgery** | 40.00% **Coinsurance** after **deductible** |
| Limit | 1 surgery per lifetime |

**Orthotic Devices**

| Description | In-Network |
|---|---|
| Orthotic devices | 40% **coinsurance** after **deductible** |

**Prosthetic Devices**

| Description | In-Network |
|---|---|
| Prosthetic devices | 40.00% **Coinsurance** after **deductible** |
| Limit | Single purchase of a type of prosthetic device every 3 years |

**Autism Spectrum Disorder**

| Description | In-Network |
|---|---|
| Autism spectrum disorder | $10 **copay**, no **deductible** applies |
| Applied behavior analysis | $10 **copay**, no **deductible** applies |
| Limit | None |

### Diabetic Equipment, Supplies And Education

| Description | In-Network |
|---|---|
| Diabetic equipment, supplies, and education | 40.00% **Coinsurance** after **deductible** |

### Temporomandibular Joint (TMJ) Treatment

| Description | In-Network |
|---|---|
| **Temporomandibular Joint (TMJ)** treatment | 40.00% **Coinsurance** after **deductible** |

### Behavioral Health

#### Mental Health Treatment

Coverage provided under the same terms, conditions as any other **illness**.

| Description | In-Network |
|---|---|
| Inpatient mental health treatment | 40.00% **Coinsurance** after **deductible** |
| Other inpatient mental health treatment services and supplies | 40.00% **Coinsurance** after **deductible** |
| Outpatient mental health treatment visits to a **physician** or **behavioral health provider** | $10 **copay**, no **deductible** applies |
| Outpatient mental health **telemedicine** or **telehealth** cognitive therapy consultations by a **physician** or **behavioral health provider** | $10 **copay**, no **deductible** applies |
| Outpatient mental health **telemedicine** or **telehealth** visit | $10 **copay**, no **deductible** applies |
| Other outpatient mental health treatment or skilled behavioral health services in the home, **partial hospitalization treatment** and **intensive outpatient program** | $10 **copay**, no **deductible** applies |

#### Substance Related Disorders Treatment

Coverage provided under the same terms, conditions as any other **illness**.

| Description | In-Network |
|---|---|
| Inpatient **substance related disorders detoxification,** rehabilitation, and treatment in a **residential treatment facility** | 40.00% **Coinsurance** after **deductible** |
| Other inpatient **substance related disorders detoxification** services and supplies, rehabilitation services and supplies, **residential treatment facility** services and supplies | 40.00% **Coinsurance** after **deductible** |
| Outpatient **substance abuse** treatment visits to a **physician** or **behavioral health provider** | $10 **copay**, no **deductible** applies |
| Outpatient **substance abuse telemedicine** or **telehealth** cognitive therapy consultations by a **physician** or **behavioral health provider** | $10 **copay**, no **deductible** applies |
| Outpatient **substance related disorders telemedicine** or **telehealth** visit | $10 **copay**, no **deductible** applies |

| | |
|---|---|
| Other outpatient **substance related disorders** services or **partial hospitalization treatment** and **intensive outpatient program** | $10 **copay**, no **deductible** applies |

**Reconstructive Surgery And Supplies**

| Description | In-Network |
|---|---|
| Reconstructive breast **surgery** | 40.00% **Coinsurance** after **deductible** |
| Other reconstructive **surgery** and supplies | 40.00% **Coinsurance** after **deductible** |

**Transplant Services**

| Description | In-Network |
|---|---|
| Services and supplies | 40.00% **Coinsurance** after **deductible** |

**Treatment Of Infertility**

| Description | In-Network |
|---|---|
| Basic **infertility** services | 40.00% **Coinsurance** after **deductible** |
| Limit | 6 cycles per lifetime |

**Gender Affirming Care**

| Description | In-Network |
|---|---|
| Gender Affirming Care | 40.00% **Coinsurance** after **deductible** |

## 11. Prescription Drugs/Medications

**Per Prescription Cost Share**

**Tier 1 - Preventive Care Drugs And Supplements**

| Description | In-Network |
|---|---|
| For each 30 day supply filled at a **retail pharmacy** | $0 per **prescription** or refill, no **deductible** applies |
| Limit | 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. |

**Tier 2 - Generic Prescription Drugs**

| Description | In-Network |
|---|---|
| For each 30 day supply filled at a **retail pharmacy** | $0 **copay**, no **deductible** applies |
| 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** | $0 **copay**, no **deductible** applies |

**Tier 3 - Preferred Brand-Name Prescription Drugs**

| Description | In-Network |
|---|---|

| | |
|---|---|
| For each 30 day supply filled at a **retail pharmacy** | 40.00% **Coinsurance** 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** | 40.00% **Coinsurance** after **deductible** |

**Tier 4 - Non-Preferred Brand-Name Prescription Drugs**

| Description | In-Network |
|---|---|
| For each 30 day supply filled at a **retail pharmacy** | 50.00% **Coinsurance** 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** | 50.00% **Coinsurance** after **deductible** |

**IMPORTANT NOTE:**

- If the **negotiated charge** or usual and customary fee is less than your **copayment**, **you** may only be required to pay the lower cost.
- Tier 2, 3 and 4 **specialty prescription drugs** are not eligible for fill at a **retail pharmacy** or **mail order pharmacy**.

**Tier 5 - Specialty Prescription Drugs**

| Description | In-Network |
|---|---|
| For each 30 day supply filled at a **specialty network pharmacy** | 50.00% **Coinsurance** after **deductible** |

**Diabetic Supplies And Insulin**

| Description | In-Network |
|---|---|
| For each 30 day supply filled at a **retail pharmacy** | Paid according to the tier of drug in the Schedule of Benefits, above |
| For all fills greater than a 30 day supply but no more than a 90 day supply filled at a **retail pharmacy** or **mail order pharmacy** | Paid according to the tier of drug in the Schedule of Benefits, above |

**Orally Administered Anti-Cancer Medications**

| Description | In-Network |
|---|---|
| For each 30 day supply filled at a **retail pharmacy** or **specialty network pharmacy** | $0 per **prescription** or refill after **deductible**. Not to exceed $100 per prescription, including any **deductible.** |

**Outpatient Contraceptive Prescription Drugs And Devices**

| Description | In-Network |
|---|---|
| Female contraceptives that are **generic prescription drugs** and OTC drugs and devices. For each 30 day supply | $0 per **prescription** or refill, no **deductible** applies |
| Female contraceptives that are **brand-name prescription drugs** and devices. For each 30 day supply | Paid according to the tier of drug in the Schedule of Benefits, above |

**IMPORTANT NOTE:**

For in-network coverage, **brand-name prescription drugs** and devices are covered at 100% when a generic is not available.

**Risk Reducing Breast Cancer Prescription Drugs**

| Description | In-Network |
|---|---|
| For each 30 day supply filled at a **retail pharmacy** | $0 per **prescription** or refill, no **deductible** applies |
| Limit | 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**

| Description | In-Network |
|---|---|
| For each 30 day supply filled at a **retail pharmacy** | $0 per **prescription** or refill, no **deductible** applies |
| Limit | • Coverage is limited to two, 90-day treatment programs only. Any additional treatment programs will be paid according to the tier of drug per the Schedule of Benefits, above.<br>• Coverage only includes a **generic prescription drug** when there is also a brand-name drug available.<br>• Coverage is subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered tobacco cessation **prescription drugs** and OTC drugs, see the *How To Contact **Us** For Help* section. |

**IMPORTANT NOTE:**

- See the *Outpatient Prescription Drugs, Other Services* section for more information on other prescription drug coverage under this plan.
- If **you** or **your prescriber** requests a covered **brand-name prescription drug** when a covered

**generic prescription drug** equivalent is available, **you** will be responsible for the cost difference between the **generic prescription drug** and the **brand-name prescription drug**, plus the cost share that applies to **brand-name prescription drugs**.