IMPERIAL INSURANCE COMPANIES

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INDIVIDUAL AND FAMILY EXPLANATION OF COVERAGE (EOC) POLICY

This **Policy** is by and between Imperial Insurance Companies, Inc. (Imperial, the Plan, **we**, **us**, or **our**) and the subscriber (**you**, **your**).

Coverage starts on **your effective date of coverage** and continues until it ends as described in this **Policy**.

Your Policy provides coverage for services and supplies that are **covered benefits**. It describes **your** coverage only. **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 provided by Imperial, a Texas domiciled health maintenance organization admitted as a health care services organization in Nevada and is governed by federal law and the laws of Nevada, including Nevada Revised Statutes Title 57(Insurance), et seq.

Read Your Policy Carefully

Your Policy is a legal contract between **you** and **us**. **We** agree to cover **you** under this **Policy** in return for **your premium** payments. **We** will pay eligible **covered benefits** while this **Policy** is in effect and after the **Policy** conditions are met.

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 want coverage described in the **Policy**, **you** may return it to **us** or to the agent who sold it to **you**. As soon as it is returned, this **Policy** will be void from the beginning. **Premiums** paid will be refunded.

Guaranteed Renewable

You can renew this **Policy** each year ("guaranteed renewable"). **We** decide the **premium** rates. But, **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.

You may keep this **Policy** in effect by meeting the **Policy** requirements and by paying the **premium** on time.

At least 60 days' notice of any plan to take an action or make a change permitted by this clause will

be delivered to **you** at y**our** last address as shown in our records. **We** will make no change in **your premium** solely because of claims made under this **Policy** or a change in a member's health. While this **Policy** is in force, **we** will not restrict coverage already in force. If **we** discontinue offering and decide not to renew all **Policies** issued on this form, with the same type and level of benefits, for all residents of the state where **you** reside, **we** will provide a written notice to **you** at least 90 days prior to the date that **we** discontinue coverage.

See the *What Does The **Policy** Cost **You**?* section of the **Policy** for more information.

Your Application

By applying for coverage under this **Policy**, or accepting its benefits, **you** (or the person acting for **you**) represent that all information in **your** application and statements given as part of **your** application for this **Policy** are true, correct and complete, to the best of **your** knowledge and belief; and **you** agree to all terms, conditions and provisions of the **Policy**.

It is **your** responsibility to make sure the application that **you** submitted is accurate and complete. It is important that **you** notify the Health Insurance Marketplace ("Marketplace") or the Plan immediately of any mistakes that **you** find in **your** application.

If **we** learn that **you** defrauded **us** or **you** intentionally misrepresented material facts when **you** gave information and answers in the application, or in the application process, **we** reserve the right to cancel the **Policy** and report fraud to criminal authorities. Please read the *Honest Mistakes And Intentional Deception* section of this **Policy** for more information.

IMPERIAL INSURANCE COMPANIES

WELCOME

This is **your Policy**. It is one of four documents that together describe the benefits **you** have and the terms of this **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.

This **Policy** is provided following **your** application for coverage. Coverage under this **Policy** is subject to any conditions and rights as set forth in this **Policy** and by the Marketplace and/or the Federal Department of Health and Human Services and the State of Nevada. Individuals covered under this **Policy** agree to all its requirements.

Sometimes, these documents have amendments, inserts or riders which **we** will send **you**. These documents change and/or add to the **Policy**. When **you** receive these, they are considered part of **your Policy**.

The **Policy**, applications, if any, and any attachments constitute the entire agreement between the parties and that, to be valid, any change in the form must be approved by an officer of the Plan and attached to the affected form. No agent has the authority to change the form or waive any of the provisions.

Where to next? Try the *Introduction to **Your** Plan* section. It gives **you** a summary of how **your Policy** works. The more **you** understand, the more **you** can get out of **your Policy**.

Welcome to **Imperial** .

IMPERIAL INSURANCE COMPANIES

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SECTION 1 – INTRODUCTION TO YOUR PLAN

Here are some basics. Please see below on how **we** use defined terms. 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. If **you** need assistance or more information, please reach out to **us**.

How We Use Defined Terms

- When **we** say "**you**" and "**your**", **we** mean **you** as the subscriber and any covered dependents if dependent coverage is available under the **Policy**.
- When **we** say "**us**", "**we**", and "**our**", **we** mean Imperial Insurance Companies, Inc.
- Some words appear in **bold** type. **We** define them in the *Definitions* section.

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

What Is Your Policy? – Provides Covered Benefits

Your Policy provides **covered benefits**. Benefits are provided for **eligible health services**. **Your Policy** has an obligation to pay for **eligible health services**.

How Does Your Policy Work? – Starts And Stops Coverage

Coverage under the **Policy** has a start and an end. First, **you** complete the eligibility and application process. Then the **Policy** is issued. **Your** coverage starts on the subscriber's **effective date of coverage**. Coverage is not provided for any services received before coverage starts or after coverage ends.

Dependent coverage starts on the subscriber's **effective date of coverage** if the subscriber enrolled them at that time. See the *Effective Date Of Coverage For **Your** Dependent* section for details.

Your coverage typically ends when **you** stop paying **your premium**. A covered dependent can lose coverage for many reasons, such as growing up and leaving home. To learn more, see the *When Coverage Ends* section.

Ending coverage under the **Policy** does not necessarily mean **you** lose coverage with **us**.

How Does Your Policy Work While You Are Covered?

Your coverage:

- Helps **you** get and pay for a lot of – but not all – health care services. Benefits are provided for **eligible health services.**
- Generally, we will pay only when **you** get care from **network providers**.

1. **Eligible health services**
   Doctor and **hospital** services are the base for many other services. **You** will typically find preventive care and wellness, **emergency services,** and **urgent condition** coverage especially important. But the **Policy** will not always cover the services **you** want. Sometimes it does not cover health care services **your** doctor will want **you** to have.

   What are **eligible health services**? They are health care services that meet these three requirements:
   - They appear in the *Coverages* section.

- They are not listed in the *General Exclusions* section. (**We** will refer to this section as the *"Exclusions"* 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** is there to give **you** the care **you** need. **You** can find **network providers** and see important information about them most easily on **our** online **provider directory**.

Visit **our** website. See the *How To Contact **Us** For Help* section.

You 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** may also go directly to a network obstetrician (OB), gynecologist (GYN), or OB/GYN for **eligible health services.**

For more information about the network and the role of **your PCP**, see the *Who Provides The Care* Section in **your Policy**.

3. Service area

Your Policy generally pays for **eligible health services** only within a specific geographic area, called a **service area**. The **service area** of this **Policy** includes Clark, Washoe, and Nye Counties. **You** must reside in the service area. There are some exceptions, such as for **emergency services** and urgent care. See the *Who Provides The Care* section in **your Policy**.

IMPORTANT NOTE:
If **you** have a dependent and the dependent moves outside of the **service area**, the dependent's coverage outside of the **service area** will be limited to emergency and **urgent conditions** for both medical and **pharmacy** services.

4. Paying for eligible health services– the 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 **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

You will find details on **medical necessity**, **referral** and **preauthorization** requirements in the *Medical Necessity, Referral And Preauthorization Requirements* section. **You** will find the requirement to use a **network provider** and any exceptions in the *Who Provides The Care* section.

5. 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 in the Schedule of Benefits in **your Policy**.

How Can You Contact Us For Help?

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

- Logging in to **our** website at **www.ImperialHealthPlan.com**
  - Register for access to reliable health information, tools and resources that help **you** to make informed decisions about **your** health care, view claims, research care and treatment options, and access information on health and wellness
  - **Our** website is available 24/7

You can also contact **us** by:

- Calling **us** at the number on **your** ID card
- Writing **us** at 1100 East Green Street Pasadena, CA 91116

Your Member ID Card

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

To get **your** ID card, log in to **our** secure website. See the *How To Contact **Us** For Help* section. **You** can print **your** ID card or request a paper copy from us by U.S. mail.

Inform The Marketplace or the Plan Of Any Changes

If there are any changes which will affect **your Policy** or the eligibility of anyone covered under the **Policy**, **you** must contact the Marketplace or the Plan as soon as possible. This may include changes in:

- Primary address
- Phone number
- Marital status, civil union parentship or domestic partnership changes
- 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** inform the Marketplace or the Plan within 31 days of the date of any change. **Your** primary address is where **you** spend 6 months or more per **calendar year**. This may also be called **your** "home address".

See the *Special Or Limited Enrollment Periods* in **your Policy** section for information on special or limited enrollment periods.

You can also enroll in a health insurance plan for you and your family through the Silver State Health Insurance Exchange (Nevada's state-based health insurance exchange). The Silver State Health Insurance Exchange allows you to get quotes from different insurance companies that are available on the Exchange. You can compare different plans, get quotes and find out if you qualify for financial assistance. The Silver State Health Insurance Exchange is the only way to receive financial assistance for your health insurance. You can enroll

online by visiting www.nevadahealthlink.com or by calling 1-800-547-2927 TTY 711.

SECTION 2 – 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 after coverage ends 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 attached Health Care Insurer Appeals Process and *When **You** Disagree – Complaint Decisions And Appeal Procedures* section of this **Policy**.

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

After **your** first **premium** payment is made, the **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 after the last day of the **premium** period.

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

Grace Period

You have a grace period of 31 days after the due date for the payment of each **premium** due after the first **premium** payment. If **premiums** are not paid by the end of the grace period, **your** coverage will automatically terminate at the last date for which the premium was paid, or as of the date required by **applicable law**.

We have the right to require the return of any payments for claims paid during the grace period for which the **premium** was not received.

IMPORTANT NOTE:
If **you** are currently getting advanced payments of the **premium** tax credit, as determined by the Marketplace, the grace period above does not apply to **you**. Instead, the following applies to **you**.

If **you** are getting advance payment of the **premium** tax credit now, and **you** have paid at least one full month's **premium** as **your** binder payment, when applicable:

- **You** will have a grace period of three months
- **Your** coverage will not end during the grace period

If **you** receive services during the second and third months of the grace period:

- **We** may wait to pay claims until the **premium** is paid
- **We** will tell **you** and **your providers** that **you** are within **your** grace period**.**

If **premium** is not paid by the end of the three-month period:

- **Your** coverage may end
- **Your** coverage will end on the last day of the first month of the grace period
- **We** may take back payment for any claims paid during the second and third months of the grace period

Reinstatement

We can end this **Policy** because **you** have not paid **your premium.** If this happens, **we** can reactivate ("reinstate") the **Policy** without a break in coverage. **You** must ask **us** to do so within 30 days of the **Policy** end date. However, **you** must first pay **us** the total **premium you** already owe plus the new **premium**. **We** reserve the right to not reinstate the **Policy**.

Premium Agreement

Your premium rate will not change during the **Policy** term so long as there are no changes to this **Policy**. Changes may include, but are not limited to, the area **you** reside in, and/or the benefit plan or adding dependents to the **Policy**.

Your premium rate is based on factors such as:

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

Each **premium** will be based on the rates that apply 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.

SECTION 3 – WHO THE POLICY COVERS

You will find information in this section about:

- Who is eligible
- Who can be on **your Policy** (who can be **your** dependent)
- Special or limited enrollment periods
- Adding new dependents
- **Effective date of coverage** for **your** dependent

Who Is Eligible

You are eligible as the subscriber if:

- You are a citizen or national of the United States, or a non-citizen who is lawfully present in the United States, and are reasonably expected to be a citizen, national, or a non-citizen who is lawfully present for the entire period for which enrollment is sought
- A legal resident of the State of Nevada
- You live in the service area in which You are applying, and intend to continue living there for the entire period for which enrollment is sought
- Not enrolled in Medicare at the time of application
- Listed as the applicant on the application

You are enrolled as the subscriber after **you** complete the eligibility and enrollment process, are approved by the Marketplace or the Plan and **we** have issued the **Policy** to **you**.

Who Can Be On Your Policy (Who Can Be Your Dependent)

You may enroll the following family members on **your Policy**. They are **your** "dependents":

- **Your** legal spouse
- **Your** civil union partner who meets eligibility requirements under **applicable law**
- **Your** domestic partner who meets eligibility requirements under **applicable law**.
- **Your** dependent children – **your** own or those of **your** spouse, domestic partner or civil union partner

  The children must be under 26 years of age, unless reliant on the parent due to physical or mental impairment, and they include **your**:
  - Biological children
  - Stepchildren
  - Legally adopted children*, including children placed with **you** for adoption
  - Foster children
  - Children **you** are responsible for under a qualified medical or dental support order or court-order (whether or not the child resides with **you**)
  - Grandchildren in **your** court-ordered custody
  - Any children approved by the Marketplace

  ***Your** adopted child may be enrolled as shown in the *When **You** Can Join The Plan* section of **your Policy** at **your** option, after the date:
  - **You** become a party in a suit for adoption, or
  - The adoption becomes final

You can enroll **your** dependent:

- At initial enrollment
- At other special times during the year as listed below

Special Or Limited Enrollment Periods

Federal law allows **you** and **your** dependents to enroll in a new **Policy** under some circumstances. These are called special or limited enrollment periods. **You** can enroll in these situations when:

- **You** or **your** dependent have 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 are enrolled in any 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 Marketplace or the Plan was unintended, was by accident or a mistake, and is due to an error, false information or delay by the Marketplace or the Plan.
- **You** or **your** dependent have proven to the Marketplace or the Plan that its plan did not honor or maintain an important provision of its contract with **you** or that **you** meet other unusual circumstances.
- **You** did not enroll a dependent in this **Policy** before because the dependent had other coverage and now that other coverage has ended.
- A court orders **you** to cover a current spouse, civil union partner, domestic partner or a child on **your** health **Policy**.
- **You** or **your** dependent are newly eligible or not eligible for the **premium** tax credit or change in eligibility for cost share reduction, for Marketplace coverage.
- **You** or **your** dependent are eligible for new plans because **you** have moved to a new permanent location.
- **You** or **your** dependent are the victim of domestic abuse or spousal abandonment.
- **You** or **your** dependent become a citizen, a national or lawfully present in the United States.
- **You** are an American Indian or Alaska Native as defined by the Indian Health Care Improvement Act. In this situation:
  - **You**, or **you** and **your** dependents, may enroll in a Qualified Health Plan (QHP) or change from one QHP to another.
  - **You** can do this one time per month.
- **You** or **your** dependent become eligible for State **premium** assistance under Medicaid or an S-CHIP plan for the payment of **your premium** contribution for coverage under this plan.
- **You** or **your** dependent lose **your** eligibility for enrollment in Medicaid or an S-CHIP plan.

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

- **You** or **your** dependent loses minimum essential coverage
- **You** or **your** dependent are enrolled in any non-**calendar year** group health plan or individual health insurance coverage
- **You** or **your** dependent are newly eligible or not eligible for the **premium** tax credit, in some cases, or change in eligibility for cost share reduction, for Marketplace coverage
- **You** or **your** dependent have access to new plans because **you** have moved to a new permanent location and either:
  - Had minimum essential coverage for at least one day during the 60 days before the date of the move

- Lived outside the Unites States or a Unites States' territory at the time of the move

Adding New Dependents

You can add the following new dependents to **your Policy**:

- A spouse - If **you** marry, **you** can put **your** spouse on **your Policy**:
  - The Marketplace or the Plan must receive **your** completed enrollment information not more than 60 days after the date of **your** marriage
  - Coverage will be effective on the first day of the month following plan selection
- A civil union partner – If **you** enter into a civil union, **you** can enroll **your** civil union partner on **your Policy**:
  - The Marketplace or the Plan must receive **your** completed enrollment information not more than 60 days after the date of **your** civil union
  - Coverage will be effective on the first day of the month following plan selection
- A domestic partner - If **you** enter a domestic partnership, **you** can enroll **your** domestic partner on **your Policy**:
  - The Marketplace or the Plan must receive **your** completed enrollment information not more than 60 days after the date **you** file a Declaration of Domestic Partnership
  - Coverage will be effective on the first day of the month following plan selection]
- A newborn child - **Your** newborn child is covered on **your Policy** for the first 60 days after birth:
  - To keep **your** newborn covered, the Marketplace or the Plan must receive **your** completed enrollment information or **you** can call to notify **us**. **You** must provide the information within 60 days of birth
  - **You** must still enroll the child within 60 days of birth even when coverage does not require payment of an additional **premium** for the covered dependent
  - If **you** miss this deadline, **your** newborn will not have benefits after the first 60 days
- An adopted child – **You** may put an adopted child on **your Policy** when **you** become a party in a suit for adoption, 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:
  - The Marketplace or the Plan must receive **your** completed enrollment information within 60 days after **you** become a party in a suit for adoption, the date of the adoption or the date the child was placed for adoption
  - Benefits for **your** adopted child will begin on the date of the adoption (or placement) or the first day of the month following adoption (or placement)
- A foster child – **You** may put a foster child on **your Policy** when the child is placed within **your** foster care. A foster child is a child whose care, comfort, education and upbringing are left to persons other than the natural parents:
  - The Marketplace or the Plan must receive **your** completed enrollment information within 60 days after the date the child is placed with **you**.
  - Benefits for **your** foster child will begin on the date **you** legally become a foster parent or the first day of the month following this event.
- A stepchild - **You** may put a child of **your** spouse, civil union partner, 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, civil union, Declaration of Domestic Partnership with **your** stepchild's parent
- Court order – **You** can put a child **you** are responsible for under a qualified medical or dental

support order or court-order on **your Policy**:

- **You** must complete **your** enrollment information and send it to the Marketplace or the Plan within 60 days after the date of the court order

Effective Date Of Coverage For Your Dependent

Your dependent's coverage will start on **your effective date of coverage**, if **you** enrolled the dependent 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

SECTION 4 – MEDICAL NECESSITY, REFERRAL, AND PREAUTHORIZATION REQUIREMENTS

The starting point for **covered benefits** under **your Policy** is whether the services and supplies are **eligible health services**. See the *Coverages* and *Exclusions* sections in **your Policy** 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** 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

That means **Your Policy** does not pay for its share of the expense for health services provided from an Out-of-Network Provider except:

- Services for Stabilization and initial treatment of an Emergency Medical Condition, or
- Medically Necessary services that are not available through an In-Network Provider.

This section addresses the **medical necessity**, **referral** and **preauthorization** requirements. **You** will find the requirement to use a **network provider** and any exceptions to this in the *Who Provides The Care* section in **your Policy**

Medically Necessary; Medical Necessity

As stated in the *Introduction to **Your** Plan* section, **medical necessity** is a requirement for **you** to receive **eligible health services** under this **Policy**.

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

Referrals

You need a **referral** from **your PCP** for most **eligible health services**. If **you** do not have a **referral** when required, **we** will not pay the **provider**. Refer to the *What the **Policy** Pays and What **You** Pay* section in **your Policy**.

Preauthorization

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

Your physician or **PCP** is responsible for obtaining any necessary **preauthorization** before **you** get the care.

A preauthorization may not be required if **your** provider meets the requirements of prior preauthorization approvals. Please contact **your** physician or **us** for additional information.

For **preauthorization** of outpatient **prescription drugs**, see *Coverages – Prescription Drugs/Medications – What Preauthorization Requirements Apply.* If **your physician** or **PCP** does not get a required **preauthorization**, **we** will not pay the **provider** who gives **you** the care. **You** will not have to pay either if

your physician or **PCP** fails to ask **us** for **preauthorization**. If **your physician** or **PCP** requests **preauthorization** and **we** refuse it, **You** have the right to appeal this decision- see the attached Health Care Insurer Appeals Process, which is included at the end of this EOC.

Your physician or PCP may request a renewal of an existing preauthorization within 60 days of the expiration date of the preauthorization. **We** will notify **you** of **our** decision before the expiration of the existing preauthorization.

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

Please see the Health Care Insurer Appeals Process, which is included at the end of this EOC and *When **You** Disagree – Complaint Decisions And Appeal Procedures* section for more information on **your** appeals rights.

SECTION 5 – COVERAGES

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 in **your Policy**.

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

For example:

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

You can find out about general **Policy** exclusions in the *General Exclusions* section in **your Policy** and about limitations in the Schedule of Benefits.

We have grouped the **eligible health services** below to make it easier for **you** to find what **you** are looking for.

IMPORTANT NOTE:
Sex-specific **eligible health services** are covered when medically appropriate, regardless of identified gender.

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

2. Diagnostic testing for the treatment or diagnosis of a medical condition is not covered under the preventive care benefit. Except for diagnostic breast imaging, **you** will pay the cost sharing specific to **eligible health services** for diagnostic testing.

3. To learn what frequency and age limits apply to routine physical exams and routine cancer screenings, contact **your physician** or **us**. See the *How To Contact **Us** For Help* section in **your Policy**. This information can also be found at **Healthcare.gov**

4. Pursuant to NRS 695C.1698, **we** will not require **you** to pay a higher **deductible**, any **copayment** or **coinsurance** or require a longer waiting period for **covered services** under the Preventive Care and

Wellness benefit.

Routine Physical Exams

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

A routine exam is a medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified **illness** or **injury**, and it includes:

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.
- Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.
- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
  - Screening and counseling services on topics such as:
    - Interpersonal and domestic violence
    - Sexually transmitted infections
    - Human Immune Deficiency Virus (HIV) infections
    - HIV pre-exposure prophylaxis (PrEP) and related services
  - Coverage of testing for and the treatment and prevention of sexually transmitted diseases, including, without limitation: Chlamydia trachomatis, gonorrhea, syphilis (including rapid point-of-care testing), human immunodeficiency virus, and hepatitis B and C
  - Unlimited coverage of condoms for members age 13 and over
  - Screening for gestational diabetes for women
  - High risk Human Papillomavirus Virus (HPV) DNA testing for women
- Radiological services, lab and other tests given in connection with the exam.
- For covered newborns, an initial **hospital** checkup and the administration of the newborn screening tests as required by applicable Nevada law including the cost of a newborn screening test kit in the amount provided by the Department of Health and Human Services.

Routine physical exams for women also include:

- Diagnostic exam for the early detection of ovarian cancer, including any other tests or screening approved by the United States Food and Drug Administration, cervical cancer, and the CA 125 blood test.
- Pap smear; or screening using liquid-based cytology methods, either alone or in conjunction with a test approved by the United States Food and Drug Administration
- Breast cancer mammography screenings

Preventive Care Immunizations

Eligible health services include immunizations provided by **your physician** for infectious diseases, including adult immunizations under the United States Department of Health and Human Services Centers for Disease Control Recommended Adult Immunization Schedule by Age Group and Medical Condition.

Immunizations for children from birth to age 18

Covered services may include:

- Diphtheria, tetanus, pertussis
- Haemophiles influenza type b

- Hepatitis B
- Inactivated poliovirus
- Measles, mumps, rubella
- Rotavirus
- Varicella
- Any other immunization that is required for children by law

Eligible Health Services also include immunizations recommended by the Immunization Practices of the Centers for Disease Control and Prevention.

The following is not covered under this benefit:
Any immunization that is not considered to be preventive care or recommended as preventive care, such as those required due to employment or travel.

Well Woman Preventive Visits

Eligible health services include **your** routine:

- Well woman preventive exam office visit to **your physician**, **PCP**, OB, GYN or OB/GYN. This includes Pap smears. **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**.
- 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.
- Screening for diabetes after pregnancy for women with a history of diabetes during pregnancy.
- Screening for urinary incontinence.

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
  - A structured assessment
- **Use of tobacco products**
  Eligible health services include the following screening and counseling services to help **you** to stop the use of tobacco products:

  - Preventive counseling visits
  - Treatment visits
  - Class visits

  Tobacco product means a substance containing tobacco or nicotine such as:
  - Cigarettes
  - Cigars
  - Smoking tobacco
  - Snuff
  - Smokeless tobacco
  - Candy-like products that contain tobacco
- **Sexually transmitted infection counseling**
  Eligible health services include the counseling services to help **you** prevent or reduce sexually transmitted infections.
- **Genetic risk counseling for breast and ovarian cancer**
  Eligible health services include the counseling and evaluation services to help **you** assess whether or not **you** are at increased risk for breast and ovarian cancer.

Routine Cancer Screenings

Eligible health services include the following routine cancer screenings:

- Mammograms
  - A single baseline mammogram if **you** are 35-39
  - Once per plan year if **you** are age 40 and older
- Prostate specific antigen (PSA) tests
- Digital rectal exams
- Fecal occult blood tests
- Sigmoidoscopies
- Double contrast barium enemas (DCBE)
- Colonoscopies, including a follow-up colonoscopy if the findings are abnormal, which includes removal of polyps performed during a screening procedure and a pathology exam on any removed polyp
- Lung cancer screenings

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
- Mandated by Nevada law

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

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

Comprehensive Lactation Support And Counseling Services

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

Family Planning Services – Female Contraceptives Counseling, Devices And Voluntary Sterilization

Eligible health services include family planning services such as:

Counseling Services

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

Devices

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

Voluntary Sterilization

Eligible health services include charges billed separately by the **provider** for female voluntary sterilization procedures and related services and supplies. This also could include tubal ligation and sterilization implants.

The following are not covered under this benefit:

- Any contraceptive methods that are only "reviewed" by the U.S. Food and Drug Administration (FDA) and not "approved" by the FDA

2. Physicians And Other Health Professionals

Physician Services

Eligible health services include services by **your physician** to treat an **illness** or **injury**. **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, teledentistry** or **telehealth**

Telemedicine may have different cost sharing. See the Schedule of Benefits for more information.

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

- Allergy testing and allergy injections
- Radiological supplies, services, and tests

- Immunizations that are not covered as preventive care

Physician Surgical Services
Eligible health services include the services of:

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

The following are not covered under this benefit:

- A **stay** in a **hospital**. See the *Coverages – Hospital And Other Facility Care* section.
- A separate facility charge for **surgery** performed in a **physician's** office.
- Service of another **physician** for the administration of a local anesthetic.

3. Inpatient and Outpatient Hospital Services

Hospital care
Eligible health services include inpatient and outpatient **hospital** care.

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** employed by the **hospital.**
- Operating and recovery rooms.
- Intensive or special care units of a **hospital**.
- General nursing care.
- Private duty nursing.
- Administration of blood and blood derivatives, including the cost of the blood or blood product (e.g. blood plasma and blood plasma expanders) that is not replaced by **you** or for **you**.
- Radiation therapy.
- Cognitive rehabilitation.
- Speech therapy, physical therapy and occupational therapy.
- Anesthesia, oxygen and oxygen therapy.
- Inhalation therapy.
- Radiological services, laboratory testing and diagnostic services.
- Meals and special diets.
- Medications.
- Intraveno**us** (IV) preparations.
- Discharge planning.
- Services and supplies provided by the outpatient department of a **hospital**.
- Dialysis care outpatient and inpatient

IMPORTANT NOTE:
Preauthorization (Prior Authorization) for Inpatient services:

- Prior Authorization is required for all non-emergency inpatient admissions, and certain other admissions, in order to be eligible for benefits. Failure to obtain prior authorization prior to an elective admission to a hospital or certain other facilities may result in a penalty or denial of payment for the services provided. Prior Authorization can be obtained by You, Your Family Member(s) or the Provider

by calling the number on the back of your ID card. To verify Prior Authorization requirements for inpatient services, including which other types of facility admissions require Prior Authorization, you can call us at the number on the back of your ID card.

- Please note that emergency admissions will be reviewed post admission. Inpatient Prior Authorization reviews both the necessity for the admission and the need for continued stay in the Hospital.

Specialty Prescription Drugs

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

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

Certain infused medications may be covered under the ***Prescription Drugs/Medications*** section.

See the *How To Contact **Us** For Help* section in **your Policy** to:

- Access the list of **specialty prescription drugs**
- Determine if coverage for a **specialty prescription drug** is under the ***Prescription Drugs/Medications*** 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.

4. Extended Care Services

Alternatives To Hospital Stays

Outpatient surgery

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

Eligible health services also include the following oral **surgery** services:

- Removal of tumors, cysts, all malignant and premalignant lesions and growths of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- Incision and drainage of facial abscess.
- **Surgical procedures** involving salivary glands and ducts and non-dental related procedures of the accessory sinuses.

Removal of complete bony impacted teeth.

IMPORTANT NOTE:

Some **surgeries** are 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.

The following are not covered under this benefit:

- A **stay** in a **hospital**. A **hospital stay** is an inpatient **hospital** benefit. See the *Coverages – Inpatient*

and Outpatient Hospital Services section in **your Policy**.
- A separate facility charge for **surgery** performed in a **physician's** office.
- Service of another **physician** for the administration of a local anesthetic.

Dental Care Services And Anesthesia In A Hospital Or Surgery Center

Eligible health services include dental care and anesthesia in a **hospital** or **surgery center** only if **your provider** tells **us you**:
- Have a physical, mental, or medical condition that requires **you** be treated in a **hospital** or **surgery center**
- Are developmentally disabled
- Are in poor health and have a medical need for general anesthesia

Home Health Care

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

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

Short-term physical, speech and occupational therapy services provided in the home are subject to the same conditions and limitations as therapy provided outside the home. See the *Short-Term Rehabilitation Services And Habilitation Therapy Services* sections and the Schedule of Benefits.

The following are not covered under this benefit:
- **Custodial care**
- Services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities)
- Transportation

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**
- Psychological and dietary counseling

- Pain management and symptom control

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

The following are not covered under this benefit:

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

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**
- Services and supplies that are provided during **your stay** in a **skilled nursing facility**

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

- The **skilled nursing facility** admission will take the place of:
  - An admission to a **hospital** or sub-acute facility.
  - A continued **stay** in a **hospital** or sub-acute facility.
- There is a reasonable expectation that **your** condition will improve enough to go home within a reasonable amount of time.

The **illness** or **injury** is severe enough to require constant or frequent skilled nursing care on a 24-hour basis.

5. Emergency Services

Eligible health services include services and supplies for the treatment of an **emergency medical condition** or an **urgent condition**.

The types of services that are eligible for coverage include:

- A medical screening examination or other evaluation, required by state or federal law and provided to covered enrollees in a **hospital** emergency facility, free-standing emergency care facility or comparable facility, necessary to determine if an **emergency medical condition** exists.
- Treatment to stabilize **your** condition.
- As always, **you** can get **emergency services** from **network providers**. However, **you** can also get

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

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 Policy . 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 requesting review, 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/free-standing emergency medical care facility) and **you** have an emergency room copay, **your copay** will be waived.
- We comply with the No Surprises Act, which protects you from receiving surprise medical bills when you are treated for emergency services. The No Surprise Act protects you from receiving surprise medical bills when you receive most emergency services, non-emergency services from out-of-network providers at in-network facilities, and services from out-of-network air ambulance service provider.

Follow-up care must be provided by **your physician**, **PCP**. Follow-up care from a **physician** other than **your PCP**, like a **specialist**, may require a **referral**. See the *Medical Necessity, Referral And Preauthorization Requirements* section in **your Policy** for more information.

In Case Of A Medical Emergency

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

Non-Emergency Condition

See the Schedule of Benefits and the *Definitions* section for specific **Policy** information.

The following is not covered under this benefit:

- Non-**emergency medical condition** care in a **hospital** emergency room facility

6. Urgent Care Services

In Case Of An Urgent Condition

Urgent condition within the service area

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

Urgent Condition Outside The Service Area

You are covered for urgent care obtained from a facility outside of the **service area** if **you** are temporarily absent from the **service area** and getting the health care service cannot be delayed until **you** return to the

service area.

Non-urgent care
See the *Exclusions* section and the Schedule of Benefits for specific plan details.

7. Pregnancy and Maternity Care

Family Planning Services – Other

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

- Voluntary sterilization for males
- Abortion to the extent the pregnancy places the women's life in serious danger or poses a serious risk of substantial impairment of a major bodily function.

The following are not covered under this benefit:

- Reversal of voluntary sterilization procedures included related follow-up care
- Services and supplies provided for an abortion except when the pregnancy places the woman's life in serious danger or poses a serious risk of substantial impairment of a major bodily function

IMPORTANT NOTE: We will not deny, limit, or seek reimbursement for maternity care because **you** are acting as a **gestational carrier**.

Maternity And Related Newborn Care

Eligible health services include prenatal and postpartum care and obstetrical services, including care and services for complications of pregnancy. After **your** child is born, **eligible health services** include:

- A minimum of 48 hours of inpatient care in a health care facility after a vaginal delivery
- A minimum of 96 hours of inpatient care in a health care facility after a cesarean delivery
- A shorter **stay**, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier

If **you** and **your physician** agree to a shorter **stay**, **you** and **your** newborn will receive timely post-delivery care. A **physician**, registered nurse, or other licensed health care **provider** can provide the post-delivery care. **You** can choose to get the post-delivery care in:

- **Your** home
- A health care **provider's** office
- A health care facility
- Another location determined to be appropriate under applicable Nevada law

Complications Of Pregnancy
Eligible health services include treatment of Complications of Pregnancy will be determined on the same basis as treatment for any other sickness.

We will cover congenital defects for a newborn the same as **we** would for any other **illness** or injury**.**

Coverage also includes the services and supplies needed for circumcision by a **provider**.

If **you** have adopted a child or a child has been placed with **you** for adoption, the costs of the child's birth will be considered eligible health services if all of these conditions are met:

- **You** adopt the child within one year of their birth

- **You** are required to pay the costs of their birth
- **You** let **us** know within 60 days that **you** have been approved to adopt

If the child's natural mother has maternity coverage of her own, **you** will need to let **us** know. Her plan will need to process the claim before **we** do.

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

Breast Pump
Eligible health services include:

- Renting a **hospital** grade electric pump while **your** newborn child is confined in a **hospital**.
- The buying of either:
  - An electric breast pump (non-**hospital** grade). **Your Policy** will cover this cost once every 12 months.
  - A manual breast pump. **Your Policy** will cover this cost once per pregnancy.

If an electric breast pump was purchased within the previous 12-month period, the purchase of another electric breast pump will not be covered until one of these things happens:

- A 12-month period has elapsed since the last purchase
- The initial electric breast pump is broken and no longer covered under a warranty

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

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

8. Pediatric

Pediatric Vision Care

Routine vision exams
Eligible health services include a routine vision exam provided by an ophthalmologist, optometrist. or any other **provider** acting within the scope of their license for children, to age 19, only. The exam will include refraction and glaucoma testing.

Vision Care Supplies
We provide vision eyewear coverage that can help pay for **prescription** eyeglasses or **prescription** contact lenses. **You** have access to an extensive network of vision locations. If **you** have questions, see the *How To Contact **Us** For Help* section.

Eligible Health Services include:

- Eyeglass frames, **prescription** lenses or **prescription** contact lenses

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

The following are not covered under this benefit:

- Special supplies such as non-**prescription** sunglasses
- Non-**prescription** eye glass frames, non-**prescription** lenses and non-**prescription** contact lenses
- Special vision procedures, such as orthoptics or vision therapy
- Acuity tests
- Eye **surgery** for the correction of vision, including radial keratotomy, LASIK and similar procedures
- Services to treat errors of refraction

Pediatric Dental Care

Eligible health services include dental services and supplies provided by a **dental provider** for children, to age 19, only. It also includes coverage health care services or procedures delivered by a preferred or contracted **health professional** as a **teledentistry** service. The **eligible health services** are those listed in the *Pediatric Dental Care* section of the Schedule of Benefits.

We will pay or otherwise discharge the Policy Benefit Level shown in your Schedule of Benefits for Essential Health Benefits when provided by a Provider and when necessary and customary under generally accepted dental practice standards and for medically necessary Orthodontic Services. Orthodontic treatment is a Benefit only when medically necessary as evidenced by a severe handicapping malocclusion and when a prior authorization is obtained. Severe handicapping malocclusion is not a cosmetic condition. Teeth must be severely misaligned causing functional problems that compromise oral and/or general health. Benefits for medically necessary orthodontics will be provided in periodic payments based on continued enrollment.

- Diagnostic and Preventive Services
    - Diagnostic: procedures to aid the Provider in determining required dental treatment.
    - Preventive: cleanings, including scaling in presence of generalized moderate or severe gingival inflammation - full mouth (periodontal maintenance is considered to be a Basic Benefit for payment purposes), topical application of fluoride solutions, space maintainers.
    - Sealants: topically applied acrylic, plastic or composite materials used to seal developmental grooves and pits in permanent molars for the purpose of preventing decay.
    - Specialist Consultations: opinion or advice requested by a general dentist.
- Basic Services
    - General Anesthesia or IV Sedation: when administered by a Provider for covered Oral Surgery or selected endodontic and periodontal surgical procedures.
    - Periodontal Cleanings: periodontal maintenance.
    - Palliative: emergency treatment to relieve pain.
    - Restorative: amalgam and resin-based composite restorations (fillings) and prefabricated stainless steel restorations for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay).
    - Crowns and Onlays/Inlays: treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam or resin-based composites.
- Major Services

- Prosthodontics: procedures for construction of fixed bridges, partial or complete dentures and the repair of fixed bridges; implant surgical placement and removal; and for implant supported prosthetics, including implant repair and recementation.
- Oral Surgery: extractions and certain other surgical procedures (including pre-and post-operative care).
- Endodontics: treatment of diseases and injuries of the tooth pulp.
- Periodontics: treatment of gums and bones supporting teeth.
- Denture Repairs: repair to partial or complete dentures, including rebase procedures and relining.
- Night Guards/Occlusal Guards: intraoral removable appliances provided for treatment of harmful oral habits.

Limitations

1. Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called “Optional Services”. Optional Services also include the use of specialized techniques instead of standard procedures.

   If an Enrollee receives Optional Services, an alternate Benefit will be allowed, which means We will base Benefits on the lower cost of the customary service or standard practice instead of on the higher cost of the Optional Service. The Enrollee will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.

2. Claims shall be processed in accordance with Our standard processing policies. The processing policies may be revised from time to time; therefore, We shall use the processing policies that are in effect at the time the claim is processed. We may use dentists (dental consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices and to determine if treatment has a favorable prognosis.
3. If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the Benefit payable under this Policy. If the Provider bills separately for the primary procedure and each of its component parts, the total Benefit payable for all related charges will be limited to the maximum Benefit payable for the primary procedure.
4. Oral examination limitations:
   a. Periodic oral evaluations are limited to once every six (6) months. See note on additional Benefits during pregnancy.
   b. Limited oral evaluations are limited to three (3) times in a six (6)-month period.
   c. Oral evaluation for a patient under three (3) years of age is covered for Enrollees aged six (6) months up to age three (3).
   d. Comprehensive oral evaluations are limited to once every 12 months.
   e. Full mouth debridement is not allowed when performed by the same dentist/dental office on the same day as evaluation procedures.
5. Application of caries arresting medicament is limited to twice per tooth per Calendar Year.
6. Image limitations:

a. We will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series when the fees for any combination of intraoral images in a single treatment series meet or exceed the Accepted Fee for a complete intraoral series.
b. When a panoramic image is submitted with supplemental image(s), We will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series.
c. If a panoramic image is taken in conjunction with an intraoral complete series, We consider the panoramic image to be included in the complete series.
d. A complete intraoral series is limited to once every 11 months.
e. A panoramic image is limited to once every 36 months.
f. Bitewing images are limited to once every six (6) months. Bitewings of any type are not billable to the Enrollee or Us within 6 months of a full mouth series.
g. Image capture procedures are not separately allowable services.

7. We will pay for routine cleanings, including scaling in presence of generalized moderate or severe gingival inflammation (including periodontal maintenance or any combination thereof) no more than once every six (6) months. Topical application of fluoride varnish and topical application of fluoride are limited to no more than twice every six (6) months. Periodontal maintenance is limited to once every three (3) months. Note that periodontal maintenance, Procedure Codes that include periodontal maintenance, are covered as a Basic Benefit, and routine cleanings are covered as a Diagnostic and Preventive Benefit.
8. Space maintainer limitations:
    a. Except for distal shoe space maintainers, space maintainers are limited to the initial appliance.
    b. A distal shoe space maintainer – fixed – unilateral is limited to children 8 and younger is limited to once per quadrant per lifetime. A separate/additional space maintainer can be allowed after the removal of a unilateral distal shoe.
    c. Limited to any combination of space maintainers not to exceed two (2) units within 12 months or four (4) units per lifetime.
    d. The removal of a fixed space maintainer is considered to be included in the fee for the space maintainer; however, an exception is made if the removal is performed by a different Provider/Provider's office.
9. Pulp vitality tests are allowed once per day when definitive treatment is not performed.
10. Cephalometric images, oral/facial photographic images and diagnostic casts are covered once in a 36-month period only in conjunction with medically necessary Orthodontic Services. If Orthodontic Services are covered, see Limitations as age limits may apply.
11. Caries risk assessments are limited to no more than once in a 12-month period.
12. Sealants are limited as follows:
    a. to permanent first and second molars limited to once per lifetime if they are without caries (decay) or restorations on the occlusal surface.
    b. do not include repair of a Sealant on any tooth within 24 months of its application.

13. Specialist Consultations count toward the oral exam frequency. Screenings of patients or assessments of patients reported individually when covered, are limited to only one in a 12-month period and included if reported, with any other examination on the same date of service and Provider office.
14. We will not cover to replace an amalgam, resin-based composite (fillings) within 36 months of treatment if the service is provided by the same Provider/Provider office. Replacement restorations within 36 months are included in the fee for the original restoration.
15. Protective restorations (sedative fillings) are allowed twice per tooth in a six (6)-month period when definitive treatment is not performed on the same date of service. The fee for protective restorations is included in the fee for any definitive treatment performed on the same date.
16. Prefabricated stainless steel crowns on baby (deciduous) teeth and prefabricated resin crowns are limited to once every 36 months. Prefabricated stainless steel crowns on permanent teeth, usually up to age 16, are limited to once per lifetime. Replacement restorations within 24 months are included in the fee for the original restoration.
17. Therapeutic pulpotomy is limited to once in a 36-month period for baby (deciduous) teeth only; an allowance for an emergency palliative treatment is made when performed on permanent teeth.
18. Root canal therapy is limited to once in a lifetime. Retreatment of root canal therapy by the same Provider/Provider office within 24 months is considered part of the original procedure.
19. Apexification is only benefited on permanent teeth with incomplete root canal development or for the repair of a perforation.
20. Retreatment of apical surgery by the same Provider/Provider office within 24 months is considered part of the original procedure.
21. Pin retention is covered twice per tooth in any 36-month period. Fees for additional pins on the same tooth on the same date are considered a component of the initial pin placement.
22. Palliative treatment is covered twice in a six (6)-month period, and the fee for palliative treatment provided in conjunction with any procedures other than required images or select Diagnostic procedures is considered included in the fee for the definitive treatment.
23. Periodontal limitations:
    a. Benefits for periodontal scaling and root planing in the same quadrant are limited to once every 12 months, not to exceed four (4) quadrants within a 12-month period. In the absence of supporting documentation, no more than two quadrants of scaling and root planing will be benefited on the same date of service. See note on additional Benefits during pregnancy.
    b. Periodontal surgery in the same quadrant is limited to once every 60 months, not to exceed four (4) quadrants within a 60-month period and includes any surgical re-entry or scaling and root planing performed within 36 months by the same dentist/office.
    c. Periodontal services, including bone replacement grafts, guided tissue regeneration, graft procedures and biological materials to aid in soft and osseous tissue regeneration are only covered for the treatment of natural teeth and are not covered when

submitted in conjunction with extractions, periradicular surgery, ridge augmentation or implants.

d. Guided tissue regenerations and/or bone grafts are not benefited in conjunction with soft tissue grafts in the same surgical area.
e. Periodontal surgery is subject to a 30-day wait following periodontal scaling and root planing in the same quadrant.
f. Cleanings (regular and periodontal) and full mouth debridement are subject to a 30-day wait following periodontal scaling and root planing if performed by the same Provider office.

24. Extractions and surgical extractions have a lifetime limit per tooth. Alveoloplasty in the same quadrant is limited to once per lifetime, not to exceed four (4) quadrants in a lifetime. Removal of cysts and lesions and incision and drainage procedures are covered once in the same day.
25. Crowns are limited to Enrollees, usually age 12 and older. Services will only be allowed on teeth that are developmentally mature.
26. Core buildup, including any pins, are covered not more than once in any 36-month period.
27. Post and core services are covered once in a lifetime.
28. When allowed within six (6) months of a restoration, the Benefit for a Crown or fixed prosthodontic service will be reduced by the Benefit paid for the restoration.
29. Labial veneer (porcelain laminate) – laboratory is limited to once in a lifetime.
30. Denture Repairs are covered not more than once in any 60-month period. Partial repairs are not covered separate for 91 days following the original repair.
31. Prosthodontic appliances that were provided under any Imperial program will be replaced only after 60 months have passed, except when We determine that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Replacement of a prosthodontic appliance not provided under an Imperial program will be made if We determine it is unsatisfactory and cannot be made satisfactory.
32. Recementation of Crowns or bridges is included in the fee for the Crown or bridge when performed by the same Provider/Provider office within six (6) months of the initial placement. After six (6) months, payment will be limited to one (1) recementation of a Crown within a 12-month period by the same Provider/Provider office.
33. The initial installation of a prosthodontic appliance is not a Benefit unless the prosthodontic appliance, bridge or denture is made necessary by natural, permanent teeth extraction occurring during a time the Enrollee was under an Imperial plan.
34. We limit payment for dentures to a standard partial or complete denture (Enrollee Coinsurances apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means and includes routine post-delivery care including any adjustments and relines for the first six (6) months after placement.

a. Dentures, removable partial dentures and relines include adjustments for six (6) months following installation. After the initial six (6) months of an adjustment or reline, adjustments and relining are each limited to one (1) per arch in a six (6)-month period. Immediate dentures, and immediate removable partial dentures include adjustments for three (3) months following installation. After the initial three (3) months of an adjustment or reline, adjustments and relining are each limited to one (1) per arch in a six (6)-month period.
b. Tissue conditioning is limited to two (2) per arch in a 12-month period. However, tissue conditioning is not allowed as a separate Benefit when performed on the same day as a denture or reline service.
c. We will not pay for implants (artificial teeth implanted into or on bone or gums), their removal or other associated procedures, but We will credit the cost of a crown, pontic or standard complete or partial denture toward the cost of the implant associated appliance (i.e., the implant supported crown or denture). The implant appliance is not covered.
d. We will not cover the replacement of any appliances for Night Guard/Occlusal Guard or Temporary Tooth Stabilization Services.

37. Frenulectomy and frenuplasty are only considered in cases of ankyloglossia (tongue-tie) interfering with feeding or speech as diagnosed and documented by a physician, or the frenum is contributing to the presence of a large diastema(s).
38. Limitations on Orthodontic Services
    a. Services are limited to medically necessary orthodontics when provided by a Provider. Orthodontic treatment is a Benefit of this dental plan only when medically necessary as evidenced by a severe handicapping malocclusion and when prior authorization is obtained.
    b. Orthodontic procedures are a Benefit only when the diagnostic casts verify a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index or one of the automatic qualifying conditions below exist.
    c. The automatic qualifying conditions are:
        i. Cleft palate deformity. If the cleft palate is not visible on the diagnostic casts written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,
        ii. A deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate,
        iii. A crossbite of individual anterior teeth causing destruction of soft tissue,
        iv. Severe traumatic deviation.
    d. The following documentation must be submitted with the request for prior authorization of services by the Provider:
        i. ADA 2006 or newer claim form with service code(s) requested.
        ii. Diagnostic study models (trimmed) with bite registration; or OrthoCad equivalent.

iii. Cephalometric radiographic image or panoramic radiographic image.
iv. HLD score sheet completed and signed by the Orthodontist; and
v. Treatment plan.

e. The allowances for comprehensive orthodontic treatment procedures (D8080, D8090) include all appliances, adjustments, insertion, removal, and post treatment stabilization (retention). No additional charge to the Enrollee is permitted.
f. Comprehensive orthodontic treatment includes the replacement, repair and removal of brackets, bands and arch wires by the original Provider.
g. Orthodontic procedures are Benefits for medically necessary handicapping malocclusion, cleft palate and facial growth management cases for Enrollees under the age of 19 and shall be prior authorized.
h. Only those cases with permanent dentition shall be considered for medically necessary handicapping malocclusion, unless the Enrollee is age 13 or older with primary teeth remaining. Cleft palate and craniofacial anomaly cases are a Benefit for primary, mixed and permanent dentitions. Craniofacial anomalies are treated using facial growth management.
i. All necessary procedures that may affect orthodontic treatment shall be completed before orthodontic treatment is considered.
j. When specialized orthodontic appliances or procedures chosen for aesthetic considerations are provided, We will make an allowance for the cost of a standard orthodontic treatment. The Enrollee is responsible for the difference between the allowance made towards the standard orthodontic treatment and the dentist's charge for the specialized orthodontic appliance or procedure.
k. Repair and replacement of an orthodontic appliance inserted under this dental plan that has been damaged, lost, stolen, or misplaced is not a covered service.
l. Orthodontics, including oral evaluations and all treatment, must be performed by a licensed dentist or their supervised staff, acting within the scope of applicable law. The dentist of record must perform an in-person clinical evaluation of the patient (or the telehealth equivalent where required under applicable law to be reimbursed as an alternative to an in-person clinical evaluation) to establish the need for orthodontics and have adequate diagnostic information, including appropriate radiographic imaging, to develop a proper treatment plan. Self-administered (or any type of "do it yourself") orthodontics are not covered.
m. The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered Benefit.

39. The fees for synchronous/asynchronous Teledentistry services are considered inclusive in overall patient management and are not separately payable services.

Exclusions

We do not pay Benefits for:

1. services that are not Essential Health Benefits unless required to by Nevada law.

2. treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state, or local agency, unless this exclusion is prohibited by law.
3. cosmetic surgery or procedures for purely cosmetic reasons.
4. provisional and/or temporary restorations (except an interim removable partial denture to replace extracted anterior permanent teeth during the healing period for children 16 years of age or under).
5. services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services for cleft lip or cleft palate provided to children at birth, children placed for adoption and adopted children so long as the children remain eligible.
6. treatment to restore tooth structure lost from wear, erosion, or abrasion or treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion. Examples include but are not limited to equilibration or abfraction.
7. any Single Procedure provided prior to the date the Enrollee became eligible for services under this plan.
8. prescribed drugs, medication, pain killers, antimicrobial agents, or experimental/investigational procedures.
9. charges for anesthesia, other than general anesthesia and IV sedation administered by a Provider in connection with covered oral surgery or selected endodontic and periodontal surgical procedures.
10. extraoral grafts (grafting of tissues from outside the mouth to oral tissues).
11. laboratory processed crowns for Enrollees, usually under age 12.
12. interim implants.
13. indirectly fabricated resin-based Inlays/Onlays.
14. overdentures.
15. charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.
16. treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision.
17. charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, image duplications, cancer screening, tobacco counseling or broken appointments are not separately payable procedures.
18. dental practice administrative services including, but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.

19. procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.
20. any tax imposed (or incurred) by a government, state, or other entity, in connection with any fees charged for Benefits provided under the Policy, will be the responsibility of the Enrollee and not a covered Benefit.
21. Deductibles and/or any service not covered under the dental plan.
22. services covered under the dental plan but exceed Benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.
23. the initial placement of any prosthodontic appliance, unless such placement is needed to replace one or more natural, permanent teeth extracted while the Enrollee is covered under the Policy or was covered under any dental care plan with Us. The extraction of a third molar (wisdom tooth) will not qualify under the above. Any such denture must include the replacement of the extracted tooth or teeth.
24. services for Orthodontic treatment (treatment of malocclusion of teeth and/or jaws) except medically necessary Orthodontics provided prior authorization is obtained.
25. services for any disturbance of the temporomandibular (jaw) joints (TMJ) or associated musculature, nerves and other tissues) except as provided under the TMJ Benefit section, if applicable.
26. services for implants (prosthetic appliances placed into or on the bone of the upper or lower jaw to retain or support dental prosthesis), their removal or other associated procedures.
27. services or supplies for fixed prosthodontics (procedures for construction of fixed bridges), except to recement a fixed partial denture.
28. services or supplies for denture rebase procedures.
29. services or supplies for inlays/onlays for treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam or resin- based composite.
30. maxillofacial prosthetics.
31. missed and/or cancelled appointments.
32. actions taken to schedule and ensure compliance with patient appointments are inclusive with office operations and are not a separately payable service.
33. the fees for care coordination are considered inclusive in overall patient management and are not a separately payable service.
34. dental case management motivational interviewing and patient education to improve oral health literacy.
35. non-ionizing diagnostic procedure capable of quantifying, monitoring, and recording changes in structure of enamel, dentin, and cementum.
36. extra-oral – 2D projection radiographic image and extra-oral posterior dental radiographic image.
37. diabetes testing.
38. corticotomy (specialized oral surgery procedure associated with orthodontics).
39. antigen or antibody testing.

40. counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use.

Note on additional Benefits during pregnancy:
When an Enrollee is pregnant, We will pay for additional services to help improve the oral health of the Enrollee during the pregnancy. The additional services each Calendar Year while the Enrollee is covered under the Policy include one (1) additional oral exam and either one (1) additional routine cleaning; one (1) additional periodontal scaling and root planing per quadrant; or one (1) additional periodontal maintenance procedure. Written confirmation of the pregnancy must be provided by the Enrollee or the Enrollee's Provider when the claim is submitted.

Teledentistry Services
Teledentistry services are dental services delivered by a dentist acting within the scope of the dentist's license, or by a health professional acting under the dentist's delegation and supervision and within the scope of the health professional's license or certification.

Teledentistry services use telecommunications and information technology to deliver the services to an Enrollee in one physical location while the dentist or health professional is located in a different physical location.

We cover Teledentistry services the same as services provided in an in-office visit.

9. 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)
- Nuclear medicine imaging including positron emission tomography (PET) scans.
- Complex imaging for preoperative testing is covered under this benefit.

Diagnostic Lab Work
Eligible health services include diagnostic lab services, and pathology and other tests, but only when **you** get them from a licensed in network lab.

Diagnostic Radiological Services
Eligible health services include radiological services (other than diagnostic complex imaging) but only when **you** get them from a licensed in network radiological facility.

IMPORTANT NOTE:
Coverage for diagnostic imaging using mammography, ultrasound imaging, or magnetic resonance imaging to evaluate an abnormality of the breast or where there is a personal history of breast cancer or dense breast tissue will be considered the same as mammograms performed for routine cancer screenings as described in the *Preventive Care And Wellness* section in **your Policy**.

Cardiovascular Disease

Eligible health services include the following noninvasive screening tests for atherosclerosis and abnormal artery structure and function every five years when performed by an in network laboratory that is certified by a recognized national organization:

- Computed tomography (CT) scanning measuring coronary artery calcifications; or
- Ultrasonography measuring carotid intima-media thickness and plaque.

Tests are available to each covered individual who is (1) a male older than 45 years of age or (2) a female older than 55 years of age. The individual must be a diabetic or have a risk of developing coronary heart disease, based on a score derived using the Framingham Heart Study coronary prediction algorithm that is intermediate or higher.

Diagnostic Follow-Up Care Related To Newborn Hearing Screening

Eligible health services includes necessary diagnostic follow-up care related to the screening tests from birth through the date the child is 24 months.

Outpatient Therapies

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 chemotherapy during a **hospital stay**. Prior authorization may apply.

Outpatient Infusion Therapy

Eligible health services include inf**us**ion 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's** office
- A home care **provider** in **your** home

See the *How To Contact **Us** For Help* section in **your Policy** to learn how **you** can access the list of preferred inf**us**ion locations.

Infusion therapy is the administration of prescribed medications or solutions through an IV.

Certain infused medications may be covered as an outpatient **prescription drug**. **You** can access the list of **specialty** and outpatient **prescription drugs**. See the *How To Contact **Us** For Help* section in **your Policy** to confirm if a drug is covered as an outpatient **prescription drug**.

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

The following are not covered under this benefit:

- Enteral nutrition
- Blood transfusions and blood products

Outpatient Radiation Therapy(Therapeutic Radiology)

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

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

Short-Term Cardiac And Pulmonary Rehabilitation Services

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

Cardiac Rehabilitation

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**.

Pulmonary Rehabilitation

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

A course of outpatient pulmonary rehabilitation may also be eligible for coverage if it is:

- Performed at a **hospital**, **skilled nursing facility**, or **physician's** office.
- **Us**ed to treat reversible pulmonary disease states.
- Part of a treatment plan ordered by **your physician**.

Short-Term Rehabilitation Services

Short-term rehabilitation services help **you** restore or develop skills and functioning for daily living. **Eligible health services** include short-term rehabilitation services **your physician** prescribes. The services have to be performed by a:

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

Short-term rehabilitation services have to follow a specific treatment plan ordered by **your physician**.

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

IMPORTANT NOTE:

When the service or therapy is considered medically necessary by **your** physician, **your** service or therapy will continue as long as the service or therapy meets or exceeds treatment goals.

Outpatient Cognitive Rehabilitation, Physical, Occupational And Speech Therapy

Eligible health services include:

- Physical therapy, but only if it is expected to improve or restore physical functions lost as a result of an acute **illness**, **injury** or **surgical procedure**.

- Occupational therapy (except for vocational rehabilitation or employment counseling), but only if it is expected to:
  - Improve, develop or restore physical functions **you** lost as a result of an acute **illness**, **injury** or **surgical procedure**.
  - Help **you** relearn skills so **you** can regain **your** ability to perform the activities of daily living on **your** own.
- Speech therapy, but only if it is expected to:
  - Improve or restore the speech function or correct a speech impairment as a result of an acute **illness**, **injury** or **surgical procedure**.
  - Improve delays in speech function development caused by a gross anatomical defect present at birth.

  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. Coverage is not restricted when used as treatment for stuttering. This benefit is available up to age 26.
- Cognitive rehabilitation associated with physical rehabilitation, but only when:
  - **Your** cognitive deficits are caused by neurologic impairment due to trauma, stroke, or encephalopathy.
  - The therapy is coordinated with **us** as part of a treatment plan intended to restore previous cognitive function.

Chiropractic

Eligible health services include spinal manipulation to correct a muscular or skeletal problem.

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

Habilitation therapy services

Habilitation therapy services are services that help **you** keep, learn, or improve skills and functioning for daily living (e.g. therapy for a child who isn't walking or talking at the expected age).

Eligible health services include habilitation therapy services **your physician** prescribes. The services have to be provided by a:

- Licensed or certified physical, occupational or speech therapist
- **Hospital, skilled nursing facility** or **hospice facility**
- **Home health care agency**
- **Physician**
- Other **provider** acting within the scope of the **provider's** license

Habilitation therapy services have to follow a specific treatment plan ordered by **your physician**.

Outpatient physical, occupational, and speech therapy

Eligible health services include:

- Physical therapy (except for services provided in an educational or training setting), if it is expected to develop any impaired function
- Occupational therapy (except for vocational rehabilitation or employment counseling or services provided in an educational or training setting), if it is expected to develop any impaired function
- Speech therapy (except for services provided in an educational or training setting or to teach sign language), provided the therapy is expected to develop speech function as a result of delayed development

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

10. Other Services and Conditions

Ambulance Service

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

- To the nearest **hospital** to provide **emergency services**
- From one **hospital** to another **hospital**, if the first **hospital** cannot provide the **emergency services** needed
- From **hospital** to **your** home or to another facility, if an **ambulance** is the only safe way to transport **you**
- From **your** home to a **hospital**, if an **ambulance** is the only safe way to transport **you**
- When during a covered inpatient **stay** at a **hospital**, **skilled nursing facility** or acute rehabilitation **hospital**, an **ambulance** is required to safely and adequately transport **you** to or from inpatient or outpatient **medically necessary** treatment

Your Policy also covers transportation to a **hospital** by professional air or water **ambulance** when:

- Professional ground **ambulance** transportation is not available
- **Your** condition is unstable and requires medical supervision and rapid transport
- **You** are travelling from one **hospital** to another and
  - The first **hospital** cannot provide the **emergency services you** need, and
  - The two conditions above are met

The following are not covered under this benefit:

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

Clinical Trial Therapies (Experimental Or Investigational)

Eligible health services include **experimental or investigational** drugs, devices, treatments or procedures from a **provider** under an “approved clinical trial” only when **you** have cancer or **terminal illnesses** and all of the following conditions are met:

- Standard therapies have not been effective or are not appropriate.
- **Your** provider determines, and **we** agree, that based on published, peer-reviewed scientific evidence that **you** may benefit from the treatment.

An "approved clinical trial" is a clinical trial that meets all of these criteria:

- The FDA has approved the drug, device, treatment or procedure to be investigated or has granted it investigational new drug (IND) or group c/treatment IND stat**us**. This requirement does not apply to procedures and treatments that do not require FDA approval.
- The clinical trial is approved by an Institutional Review Board that will oversee the investigation.
- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization.
- The trial conforms to standards of the NCI or other, applicable federal organization.
- The clinical trial takes place at an NCI-designated cancer center or takes place at more than one institution.
- **You** are treated in accordance with the protocols of that study.

Clinical Trials (Routine Patient Costs)

Eligible health services include "routine patient costs" incurred by **you** from a **provider** in connection with participation in a phase I, phase II, phase III or phase IV "approved clinical trial" as a "qualified individual" for the prevention, detection or treatment of cancer or other life-threatening disease or condition, as those terms are defined in the federal Public Health Service Act, Section 2709. An approved clinical trial must satisfy one of the following:

- Federally funded trials:
  - The study or investigation is approved or funded by one or more of the following:
    - The National Institutes of Health
    - The Centers for Disease Control and Prevention
    - The Agency for Health Care Research and Quality
    - The Centers for Medicare & Medicaid Services
    - Cooperative group or center of any of the entities described above or the Department of Defense or the Department of Veterans Affairs
    - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
    - The Department of Veterans Affairs
    - The Department of Defense
    - The Department of Energy
    - The Food and Drug Administration
    - An institutional review board of a Nevada institution that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application

The following are not covered under this benefit:

- Services and supplies related to data collection and record-keeping that is solely needed due to the clinical trial (i.e. protocol-induced costs)
- Services and supplies provided by the trial sponsor without charge to **you**
- The experimental intervention itself (except **medically necessary** Category B investigational devices and promising **experimental or investigational** interventions for **terminal illnesses** in certain clinical trials in accordance with **our** claim policies)

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 Policy** will cover either buying or renting the item, depending on which **we** think is more cost efficient. If **you** purchase **DME**, that purchase is only eligible for coverage if medically necessary.

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

Coverage includes:

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

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

The following are not covered under this benefit:

- Whirlpools
- Portable whirlpool pumps
- Massage table
- Sauna baths
- Message devices (personal voice recorder)
- Over bed tables
- Elevators
- Communication aids, except for hearing aids covered under the *Hearing Aids And Exams* section
- Vision aids
- Telephone alert systems

Hearing Aids

Eligible health services include prescribed hearing aids and hearing aid services as described below.

Hearing aid means:

- Any wearable, non-disposable instrument or device designed to aid or make up for impaired hearing
- Parts, attachments or accessories

Hearing aid services are:

- Audiometric hearing visit and evaluation for a hearing aid **prescription** performed by:
  - A **physician** certified as an otolaryngologist or otologist
  - An audiologist who is legally qualified in audiology, or holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any licensing requirements and who performs the exam at the written direction of a legally qualified otolaryngologist or otologist
  - Any in network **provider** acting within the scope of the **provider's** license
- Electronic hearing aids, installed in accordance with a **prescription** written during a covered hearing exam
- Any other related services necessary to access, select and adjust or fit, including ear molds to maintain optimal fit of a hearing aid
- Habilitation and rehabilitation necessary for educational gain
- Limited to one per ear per year.

The following are not covered under this benefit:

- A replacement of:
  - A hearing aid that is lost or stolen
- Replacement parts or repairs for a hearing aid
- Batteries or cords
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss
- Any ear or hearing exam performed by a physician who is not certified as an otolaryngologist or otologist
- Any tests, appliances and devices to:
  - Improve **your** hearing, including hearing aid batteries and auxiliary equipment
  - Enhance other forms of communication to make up for hearing loss or devices that

simulate speech

Hearing Aids And Cochlear Implants And Related Services

Eligible health services include cochlear implants and the following related services and supplies:

- Fitting and dispensing services and ear molds necessary to maintain optimal fit of hearing aids
- Treatment related to cochlear implants, including:
  - Habilitation and rehabilitation necessary for educational gain
  - For cochlear implants, an external speech processor and controller
- Internal replacement of cochlear implants as medically or audio logically necessary

The following are not covered under this benefit:

- Hearing aids and Cochlear implants and related services, except as described above

For coverage of drugs available only on the orders of a physician please refer to the *Coverages – Prescription Drugs/Medications* section in **your Policy**.

Orthotic devices

Eligible health services include the initial orthotic device and subsequent replacement that **your physician** orders and administers.

Obesity (Bariatric) Surgery

Eligible health services include the treatment of **morbid obesity** and **bariatric surgical procedure** including related outpatient services.

The following are not covered under any other benefit:

- Weight management treatment or drugs intended to decrease or increase body weight, control weight or treat obesity, including **morbid obesity**, except as described above and in the *Coverages - Preventive care and wellness* section, including preventive services for obesity screening and weight management interventions. This is regardless of the existence of other medical conditions. Examples of these are:
  - Liposuction, open vertical banded gastroplasty, laparoscopic vertical banded gastroplasty, open sleeve gastrectomy, and open adjustable gastric banding
  - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications
  - Hypnosis or other forms of therapy
  - Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement

Prosthetic Devices

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

We will cover the same type of devices that are covered by Medicare. **Your provider** will tell **us** which device best fits **your** needs. But, **we** cover it only if **we preauthorize** the device.

Prosthetic device means:

- 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**

Coverage includes:

- Repairing or replacing the original device unless **you** misuse or lose the device. Examples of these are: 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

The following are not covered under this benefit:

- Services covered under any other benefit
- Repair and replacement due to loss, misuse, abuse or theft

Autism Spectrum Disorder

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

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

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

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

IMPORTANT NOTE: There is no maximum benefit limit for Autism Spectrum Disorder benefits, but benefits may require prior authorization. For more details on cost sharing, see the Schedule of Benefits.

Diabetic Equipment, Supplies And Education

Eligible health services include:

- Services
  - Foot care to minimize the risk of infection
- Supplies
  - Diabetic needles, syringes and pens
  - Test strips – blood glucose, ketone and urine
  - Injection aids for the blind
  - Blood glucose calibration liquid
  - Lancet devices and kits
  - Alcohol swabs
- Equipment
  - External insulin pumps and pump supplies
  - Blood glucose monitors without special features, unless required due to blindness
- Education
  - Self-management training provided by a health care **provider** certified in diabetes self-management training

This coverage is for the treatment of insulin dependent (type I) and non-insulin dependent (type II)

diabetes and the treatment of elevated blood glucose levels during pregnancy or another medical condition associated with elevated blood glucose levels. See the *Prescription Drugs/Medications* section for diabetic supplies that **you** can get at a **pharmacy**.

All supplies, including medications and equipment for controlling diabetes shall be dispensed as written unless a substitution is approved by **your** physician who issues the written order.

Jaw Joint Disorder Treatment

Eligible health services include the diagnosis and surgical treatment of **jaw joint disorder** by a **provider** which includes:

- The jaw joint itself, such as temporomandibular joint dysfunction (TMJ) syndrome
- Involving the relationship between the jaw joint and related m**us**cles and nerves such as myofascial pain dysfunction (MPD)

Sickle Cell Disease

Eligible Health services include the treatment of Sickle Cell Disease and its variants, including medically necessary prescription drugs.

Behavioral Health

Mental health treatment

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

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

- Peer counseling support by a peer support specialist. A peer support specialist serves as a role model, mentor, coach, and advocate. Peer support must be supervised by a **behavioral health provider**.

Eligible health services will be covered on the same terms and conditions as medical and surgical benefits for any other physical illness.

Substance Related Disorders Treatment
Eligible health services include the treatment of **substance related disorders** provided by a **hospital**, **psychiatric hospital**, **residential treatment facility**, **physician** or **behavioral health provider** as follows:

- **Inpatient room and board** at the **semi-private room rate** (the **Policy** will cover the extra expense of a private room when appropriate because of **your** medical condition) and other services and supplies provided during **your stay** in a **hospital**, **psychiatric hospital** or **residential treatment facility**.
- Outpatient treatment received while not confined as an inpatient in a **hospital**, **psychiatric hospital** or **residential treatment facility**, including:
  - Office visits to a **physician** or **behavioral health provider** such as a **psychiatrist**, psychologist, social worker or licensed professional counselor (includes **telemedicine or telehealth** consultation).
  - Other outpatient **substance related disorders** treatment such as:
    - Outpatient detoxification.
    - **Partial hospitalization treatment** provided in a facility or program for **substance related disorders** treatment provided under the direction of a **physician.**
    - **Intensive outpatient program** provided in a facility or program for **substance related disorders** treatment provided under the direction of a **physician.**
    - Ambulatory detoxification which are outpatient services that monitor withdrawal from alcohol or other **substance related disorders**, including administration of medications.
    - Treatment of withdrawal symptoms, including coverage for all FDA approved drugs to support safe withdrawal from substance use disorder and for medication-assisted treatment for opioid use disorder
    - Services provided by a pharmacist, including:
      - Assessing a patient to determine whether the patient has an opioid use disorder; and whether medication-assisted treatment would be appropriate for the patient;
      - Counseling and providing information to the patient concerning evidence-based treatment for opioid use disorders, including, without limitation, medication-assisted treatment; and
      - Prescribe and dispense a drug for medication-assisted treatment.
    - Observation.
    - Peer counseling support by a peer support specialist. A peer support specialist serves as a role model, mentor, coach, and advocate. Peer support must be supervised by a **behavioral health provider**.
    - Lofexidine, Buprenorphine, Methadone, and Naltrexone

Eligible health services will be covered on the same terms and conditions as medical and surgical benefits for any other physical illness.

IMPORTANT NOTE:

The plan will not impose treatment limitations on benefits for mental **health disorders** or **substance related disorders** that are generally more restrictive than treatment limitations imposed on coverage of benefits for medical or surgical expenses.

Reconstructive Surgery And Supplies

Eligible health services include all stages of reconstructive **surgery** and related supplies provided in an inpatient or outpatient setting only in the following circumstances:

- **Your surgery** reconstructs the breast where a necessary mastectomy was performed, such as an implant and areolar reconstruction. It also includes **surgery** on a healthy breast to make it even with the reconstructed breast, treatment of physical complications of all stages of the mastectomy, including lymphedema, and prostheses.
- **Your surgery** corrects an accidental **injury**. The **surgery** must be performed as soon as medically feasible. **Injuries** that occur during medical treatments are not considered accidental **injuries**, even if unplanned or unexpected. **Surgery** to fix teeth injured due to an accident is covered when:
  - Teeth are sound natural teeth. This means the teeth were stable, functional, and free from decay or disease at the time of the **injury**.
  - The **surgery** returns the injured teeth to how they functioned before the accident.
- **Your surgery** is needed to improve a significant functional impairment of a body part.
- **Your surgery** corrects a gross anatomical defect, including a congenital dental defect, present at birth or appearing after birth (but not the result of an **illness** or **injury**). The **surgery** will be covered if:
  - The defect results in severe facial disfigurement or major functional impairment of a body part.
  - The purpose of the **surgery** is to improve function.
- **Your surgery** corrects a craniofacial abnormality. This includes an abnormal structure that is caused by developmental deformities, congenital defects, trauma, tumors, infections or disease. The **surgery** will be covered if:
  - The purpose of the **surgery** is to improve function or attempt to create a normal appearance.

Transplant Services

Eligible health services include transplant services provided by a **physician** and **hospital**.

This includes the following transplant types:

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

Network Of Transplant Facilities

We designate facilities to provide specific services or procedures. They are listed in **your** provider directory.

You must get transplant services from the facility **we** designate to perform the transplant **you** need. You are subject to the network **copayment, deductible,** maximum out of pocket and limits where you received transplant services. .

The following are not covered under this benefit:

- Services and supplies furnished to a donor when the recipient is not a covered person

- Harvesting and storage of organs, without intending to use them for immediate transplantation for **your** existing **illness**
- Harvesting and/or storage of bone marrow, hematopoietic stem cells or other blood cells without intending to use them for transplantation within 12 months from harvesting, for an existing **illness**

Treatment Of Infertility

Basic infertility services

Eligible health services include seeing a **network provider**:

- To diagnose and evaluate the underlying medical cause of **infertility**.
- To preserve fertility when undergoing treatment for breast or ovarian cancer when the cancer itself or its treatment may cause infertility.
- Covered Services do not include those services specifically excluded herein, but do include limited:
  - Laboratory studies;
  - Cryopreservation (freezing) of eggs, embryos or sperm;
  - Diagnostic procedures; and
  - Artificial insemination services, up to six (6) cycles per Member per lifetime.

The following are not covered under the infertility services benefits:

- All charges associated with:
  - Surrogacy for **you** or the surrogate. 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.
  - Storage of eggs, embryos or sperm.
  - Thawing of cryopreserved (frozen) eggs, embryos or sperm.
  - The care of the donor in a donor egg cycle. This includes, but is not limited to, any payments to the donor, donor screening fees, fees for lab tests and any charges associated with care of the donor required for donor egg retrievals or transfers.
  - The use of a gestational carrier for the female acting as the gestational carrier. A gestational carrier is a female carrying an embryo to which she is not genetically related.
- Home ovulation prediction kits or home pregnancy tests.
- Injectable **infertility** medication, including but not limited to menotropins, hCG and GnRH agonists.
- The purchase of donor embryos, donor oocytes or donor sperm.
- Reversal of voluntary sterilizations, including follow-up care.
- Any charges associated with obtaining sperm from a person not covered under this plan for ART services.
- Ovulation induction with menotropins, intrauterine insemination and any related services, products or procedures.
- In vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers and any related services, products or procedures (such as Intracytoplasmic sperm injection (ICSI) or ovum microsurgery).
- To do **surgery** to treat the underlying medical cause of **infertility**. Examples are endometriosis surgery or, for men, varicocele surgery.

Gender Affirming Care

Eligible health services include medically necessary treatment of conditions relating to gender dysphoria and gender incongruence. This includes coverage of medically necessary psychosocial and surgical intervention and any other medically necessary treatment for such disorders provided by:

- Endocrinologists;
- Pediatric endocrinologists;
- Social workers;
- Psychiatrists;
- Psychologists;
- Gynecologists;
- Speech-language pathologists;
- Primary care physicians;
- Advanced practice registered nurses;
- Physician assistants; and
- Any other providers of medically necessary services for the treatment of gender dysphoria or gender incongruence.

11. Prescription Drugs/Medications

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**
- **Eligible health services** under **your Policy**
- Other services
- How **you** get an emergency **prescription** filled
- Where **your** Schedule of Benefits fits in
- What **preauthorization** requirements apply
- How can I request a medical exception request
- Prescribing units

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

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

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

There is another type of **preauthorization** for **prescription drugs**, and that is **step therapy**. **Step therapy** will not apply to **prescription drugs** used for the treatment of stage –four advanced, metastatic cancer or associated conditions. If **your doctor** believes the step therapy protocol should be overridden in favor of immediate coverage contact us at **www.ImperialHealthPlan.com** to request a step therapy exception. **You** will find the **step therapy prescription drugs** on the **drug guide**. For the most up-to-date information, call **us** or go online. See the *How To Contact **Us** For Help* section in **your Policy** for details. **IMPORTANT NOTE:** Imperial will not require **Step Therapy** for the use of FDA approved drugs used to treat psychiatric conditions.

How To Access Network Pharmacies

How To 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.

You may go to any of **our network pharmacies**. If **you** do not get **your prescriptions** at a **network pharmacy**, **your prescriptions** will not be covered as **eligible health services** under the **Policy**. **Pharmacies** include network **retail**, **mail order** and **specialty pharmacies**.

If The Pharmacy You Have Been Using Leaves The Network

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

Eligible Health Services Under Your Policy

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

- They are listed in the *Coverages* section
- They are not listed in the *Exclusions* 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, Referral And Preauthorization Requirements* section.
- **You** need to show **your** ID card to the **pharmacy** when **you** get a **prescription** filled.

We base **your prescription** drug plan on drugs listed in the **drug guide**. **We** exclude **prescription** drugs not in the **drug guide** unless **we** approve a medical exception request. Any prescription drug approved or covered under the plan for a medical condition or mental illness and has been removed from the drug guide before **your** plan renewal will be covered at the contracted benefit level until the plan's renewal date. **Our** Pharmacy & Therapeutics (P&T) Committee meets no less than quarterly to review existing therapeutic classes as well as new drugs to the market. The P&T Committee's clinical decisions are based on scientific evidence, standards of practice, peer-reviewed medical literature, accepted clinical practice guidelines, and other sources of appropriate information. If it is **medically necessary** for **you** to use a **prescription** drug that is not on this **drug guide**, **you** or **your provider** must request a medical exception. See the *Requesting A Medical Exception* section for more information.

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

- Limiting coverage of the applicable drugs to one prescribing **provider** and/or one **network pharmacy**
- Limiting the quantity, dosage or day supply
- Requiring a partial fill or denial of coverage

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

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

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

Partial Fill Dispensing For Certain Prescription Drugs

We allow a partial fill of **your prescription** if:

- **Your pharmacy** or **prescriber** tells **us** that:
  - The quantity requested is to synchronize the dates that the **pharmacy** fills **your prescription drugs**
  - The synchronization of the dates is in **your** best interest
- **You** agree to the synchronization

Your out-of-pocket expenses will be prorated based on the number of days' supply.

Retail Pharmacy

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

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.

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. See the *How To Contact **Us** For Help* section in **your Policy** for how to access the list of **specialty prescription drugs**.

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

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.

Except as stated below, if You redeem a coupon or other offer from a pharmaceutical manufacturer for a Prescription Drug or Related Supply covered under this Policy, we may not allow the dollar value of the coupon, or other offer to reduce any applicable **deductibles**, **maximum out-of-pocket limit**, **copayment** or **coinsurance**. We have the right to determine the amount and duration of any reduction, coupon or financial incentive available for any specific drug covered under this Policy.

If **You** redeem a coupon or other offer for Brand Name Drugs that do not have a Generic equivalent or drugs obtained through Prior Authorization, Step Therapy or an exceptions and appeals process covered under this Policy, we will allow the dollar value of the coupon, or other offer to reduce any applicable **deductibles**, **maximum out-of-pocket limit**, **copayment** or **coinsurance**.

Other Services

Preventive Contraceptives

For females who are able to become pregnant, **your** outpatient **prescription drug** plan covers up to a 12-month supply of certain drugs and devices that the FDA has approved to prevent pregnancy. This includes contraception provided in a hospital immediately following childbirth. This includes self-administered hormonal contraceptives without a **prescription. Your** outpatient **prescription drug** plan also covers related services and supplies needed to administer covered devices. At least one form of contraception in each of the 18 methods identified by the FDA is included and covered at no cost to **you**. **You** can access the list of contraceptive drugs. For a complete list, please visit https://www.fda.gov/consumers/free-publications-women/birth-control-chart.

HIV Pre-Exposure Prophylaxis (PrEP) And Preventive Contraceptives

We cover over-the-counter (OTC) and **generic prescription drugs** and devices for each of the methods identified by the FDA at no cost share. If a **generic prescription drug** or device is not available for a certain method, **you** may obtain certain **brand-name prescription drugs** or devices for that method at no cost share.

Diabetic Supplies

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

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

See the *Coverages - Specific Conditions - Diabetic Equipment, Supplies And Education* section in **your Policy** for coverage of blood glucose meters and insulin pumps and for diabetic supplies that **you** can get from other **providers**.

Immunizations

Eligible health services include preventive immunizations as required by the guidelines established by the Affordable Care Act (ACA) when administered at a **network pharmacy**. Call the pharmacy for vaccine availability, as not all pharmacies will stock all available vaccines.

Biomarker Testing

Eligible health services include coverage for **biomarker** testing for the purposes of diagnosis, treatment, appropriate management or ongoing monitoring of a disease or condition to guide treatment decisions when the test provides **clinical utility** as demonstrated by medical and scientific evidence, including any of the following:

- Labeled indications for tests that are approved or cleared by the United States Food and Drug Administration or indicated tests for a drug that is approved by the United States Food and Drug Administration
- Center for Medicare and Medicaid services national coverage determinations or Medicare administrative contractor local coverage determinations
- **Nationally recognized clinical practice guidelines** and **consensus statements**

Nutritional Support

Eligible health services include coverage for formula and low protein modified food products ordered by a **physician** for the treatment of phenylketonuria or an inherited disease or disorder of amino and organic acids. This includes coverage for amino acid-based elemental formula.

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

Orally Administered Anti-Cancer Drugs, Including Chemotherapy Drugs

Eligible health services include any drug prescribed for the treatment of cancer if it is recognized for treatment of that indication in a standard reference compendium or recommended in the medical literature even if the drug is not approved by the FDA for a particular indication. Coverage for oral anti-cancer **prescription drugs** will not be less favorable than for intravenously or injected anti-cancer **prescription drugs**. **Your prescriber** or **your** pharmacist may need to get approval from **us** before **we** will agree to cover the drug for **you**. See the *Preauthorization* section in **your Policy** for details.

Prescription Eye Drops

You may refill **prescription** eye drops to treat a chronic eye disease or condition if:

- The original **prescription** states that additional quantities are needed
- The refill does not exceed the total quantity of dosage units stated on the original **prescription**, including refills
- The refill dispensed on or before the last day of the prescribed dosage period and not earlier than the:
  - 21st day after the date a 30-day supply is dispensed
  - 42nd day after the date a 60-day supply is dispensed
  - 63rd day after the date a 90-day supply is dispensed

Preventive Care Drugs And Supplements

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

Risk Reducing Breast Cancer Prescription Drugs

Eligible health services include **prescription drugs** used to treat people who are at:

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

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.

The following are not covered under this benefit:

- Abortion drugs
- Allergy serum and extracts administered by injection
- Any services related to the dispensing, injection or application of a drug
- Biological liquids and fluids unless specified on the **drug guide**
- **Cosmetic** drugs
  - Medications or preparations used for **cosmetic** purposes
- Compound **prescriptions** containing bulk chemicals that have not been approved by the FDA, including compounded bioidentical hormones
- Devices, products and appliances, except those that are specifically covered
- Dietary supplements including medical foods
- Drugs or medications:
  - Which do not, by **applicable law**, require a **prescription** order (i.e., over-the-counter (OTC) drugs), even if a **prescription** is written, except where stated above
  - That is therapeutically equivalent or a therapeutic alternative to a covered **prescription drug** unless a **prescription drug** exception is approved
  - Recently approved by the FDA, but which have not yet been reviewed by **our** Pharmacy and Therapeutics Committee
  - That includes vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
  - For which the cost is covered by a federal, state or government agency (for example: Medicaid or Veterans Administration)
  - Not approved by the FDA or not proven to be safe and effective
  - 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 preauthorization** and clinical policies
- Duplicative drug therapy (e.g. two antihistamine drugs)
- 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
- Immunization or immunological agents except as specifically provided in the *Coverages – Prescription Drugs/Medications* section
- Implantable drugs and associated devices except where stated above
- **Infertility**
  - **Prescription drugs** used primarily for the treatment of **infertility** except where stated in the *Coverages – Treatment Of Infertility* section
- Injectables:
  - Any charges for the administration or injection of **prescription drugs** or injectable insulin and other injectable drugs covered by **us**.
  - Needles and syringes, except those used for insulin administration.
  - For any drug, which due to its characteristics, as determined by **us**, must typically be administered or supervised by a qualified **provider** or licensed certified **health professional** in an outpatient setting. This exception does not apply to Depo Provera and other injectable drugs used for contraception.
- Off-label drug use except for indications recognized through peer-reviewed medical literature or a

prescription drug reference compendium approved by the commissioner

- **Prescription Drugs:**
  - That are ordered by a **dentist** or prescribed by an oral surgeon in relation to the removal of teeth, or **prescription drugs** for the treatment of a dental condition unless dental benefits are provided under **your Policy**.
  - That are considered oral dental preparations and fluoride rinses, except pediatric fluoride tablets or drops as specified on the **drug guide**.
  - That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance or drugs obtained for use by anyone other than the member identified on the ID card.
- Replacement of lost or stolen **prescriptions**
- Tobacco cessation drug unless recommended by the United States Preventive Services Task Force (USPSTF). See the *Coverages – Tobacco Cessation Prescription And Over-The-Counter Drugs- Prescription Drugs/Medications* section.
- Test agents except diabetic test agents
- A manufacturer's product when the same or similar drug (one with the same active ingredient or same therapeutic effect), supply or equipment is on the plan's **drug guide**
- Any dosage or form of a drug when the same drug is available in a different dosage or form on the plan's **drug guide**

How You Get An Emergency Prescription Filled

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

Type Of Pharmacy	Your Cost Share
Network pharmacy	• **You** pay the **copayment**.
Type Of Pharmacy	**Your Cost Share**
Out-of-Network pharmacy	• **You** pay the **pharmacy** directly for the cost of the **prescription**. Then **you** fill out and send a **prescription drug** refund form to **us**, including all itemized **pharmacy** receipts. • Coverage is limited to items obtained in connection with covered emergency and out-of-area urgent care services. • Submission of a claim does not guarantee payment. If **your** claim is approved, **you** will be reimbursed the cost of **your prescription** less **your network copayment**.

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 **Policy**.

Your prescription drug costs are based on:

- The type of **prescription you** use

- Where **you** fill **your prescription**

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

What Preauthorization Requirements Apply

Why Some Drugs Need Preauthorization

For certain drugs, **you**, **your prescriber** or **your** pharmacist needs to get approval from **us** before **we** will cover the drug. This is called "**preauthorization.**" The requirement for getting approval in advance guides appropriate use of preauthorized drugs and makes sure they are **medically necessary**. For the most up-to-date information, call **us** or go online. See the *How To Contact **Us** For Help* section in **your Policy** for details.

There is another type of **preauthorization** for **prescription drugs**, and that is **step therapy**. **Step therapy** will not apply to **prescription drugs** used for the treatment of stage –four advanced, metastatic cancer or associated conditions. **You** will find the **step therapy prescription drugs** on the **drug guide**. For the most up-to-date information, call **us** or go online. See the *How To Contact **Us** For Help* section in **your Policy** for details.

How To Request A Medical Exception

Sometimes **you** or **your provider** may ask for a **medical** exception for drugs that are not covered. **You**, someone who represents **you**, or **your provider** can contact **us**. **You** will need to provide **us** with the required clinical documentation. Any exception granted is based upon an individual and is a case-by-case decision. For directions on how **you** can submit a request for a review:

- Visit the website at: https://exchange.imperialhealthplan.com/wp-content/uploads/2024/07/How-to-Request-a-Medical-Exception.docx
- Call **us** or contact **us** through **our** website at www.ImperialHealthPlan.com. For details, see the *Contact **Us** For Help* section in **your Policy**.

You, someone who represents **you**, or **your provider** may seek a quicker **medical** exception when the situation is urgent. It is an urgent situation when **you** have a health condition that may seriously affect **your** life, health, or ability to get back maximum function. It can also be when **you** are going through a current course of treatment using a non-covered drug. A formulary exception request for a drug that is not listed in the **drug guide** is an adverse determination and **you** can have the adverse determination reviewed as an appeal of an adverse determination including an expedited appeal. See the attached Health Care Insurer Appeals Process.

Prescribing units

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

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

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

SECTION 6 – GENERAL EXCLUSIONS

We already told **you** about the many health care services and supplies that are eligible for coverage under **your Policy** in the *Coverages* section. In that section, **we** also told **you** that some health care services and supplies have exceptions and some are not covered at all (exclusions). For example, **physician** care is an **eligible health service** but **physician** care for **cosmetic surgery** is not covered. This is an exclusion.

In this section, **we** tell **you** about the exclusions that apply to **your Policy**.

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

The following are not **eligible health services** under **your Policy** except as described in the *Coverages* section of this **Policy** or by a rider or amendment included with this **Policy**:

Acupuncture

Your Policy does not cover services for acupuncture.

Behavioral Health Treatment

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

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

Blood, Blood Plasma, Synthetic Blood, Blood Derivatives Or Substitutes, (Except As Described In The *Coverages – Hospital Care* Section)

Examples of these are:

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

For allogenic and autologous blood donations, only administration and processing expenses are covered. **We** do not cover volunteer donation expenses for which there is no charge

Clinical Trial Therapies (Experimental Or Investigational)

- **Your Policy** does not cover clinical trial therapies (**experimental or investigational**), except where described in the *Coverages - Clinical Trial Therapies (Experimental Or Investigational)* section.

Cosmetic Services And Plastic Surgery

- Any treatment, **surgery** (**cosmetic** or plastic), service or supply to alter, improve or enhance the

shape or appearance of the body, except where described in the *Coverages* section

Court-Ordered Testing

- Court-ordered testing or care unless **medically necessary**

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 continuo**us**) feedings.
- Care of a bladder catheter (including emptying/changing containers and clamping tubing).
- Watching or protecting **you**.
- Respite care, adult (or child) day care, or convalescent care.
- Institutional care. This includes **room and board** for rest cures, adult day care and convalescent care.
- Help with walking, grooming, bathing, dressing, getting in or out of bed, going to the bathroom, eating or preparing foods.
- Any other services that a person without medical or paramedical training could be trained to perform.
- Any service performed by a person without any medical or paramedical training.

Educational Services

Examples of those services are:

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

Examinations

Any health or dental examinations needed:

- Because a third party requires the exam. Examples include examinations to get or keep a job, 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)

Please see the *When **You** Disagree - Complaint Decisions And Appeal Procedures section and the attached Health Care Insurer Appeals Process* for more information on **your** appeals rights in these situations.

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

Foot Care

- Services and supplies for:
  - The treatment of calluses, bunions, 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, except for c3omplications of diabetes. See the *Specific Conditions* section.

Gene-Based Therapies (GBT)

Gene-Based Therapies are excluded from coverage unless **you** receive prior written approval from **us.**

Growth/Height care

- A treatment, device, drug, service or supply to increase or decrease height, or alter the rate of growth
- **Surgical procedures**, devices and growth hormones to stimulate growth

Maintenance Care

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

Medical Supplies – Outpatient Disposable

- Any outpatient disposable supply or device. These items are usually included in the cost of other services and are not billed separately. Examples of these include:
  - Sheaths
  - Bags
  - Support hose
  - Bandages
  - Bedpans
  - Syringes, except for treatment of diabetes
  - Blood or urine testing supplies, except for treatment of diabetes
  - Other home test kits
  - Splints
  - Neck braces

- Compresses
- Other devices not intended for re**use** by another patient

Nutritional Support

Obesity (Bariatric) Surgery And Weight Management

- Weight management treatment or drugs intended to decrease or increase body weight, control weight or treat obesity, including **morbid obesity**, except as described in the *Coverage And Exclusions - Preventive Care And Wellness* section, including preventive services for obesity screening and weight management interventions. This is regardless of the existence of other medical conditions. Examples of these are:
  - Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric **surgery**
  - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications
  - Hypnosis or other forms of therapy
  - Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement

Orthotic Devices

- Services covered under any other benefit
- Repair and replacement due to loss, misuse, abuse or theft

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.

Personal Care, Comfort Or Convenience Items

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

Services Provided By A Family Member

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

Services, Supplies And Drugs Received Outside Of The United States

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

Strength And Performance

- Services, devices and supplies such as drugs or preparations designed primarily to enhance **your**

strength, physical condition, endurance or physical performance, except when used to treat an **illness** or **injury**.

Telemedicine, Teledentistry Or Telehealth

- Services given by **providers** that are not contracted with us as **telemedicine providers**
- Services given when **you** are not present at the same time as the **provider**
- Telemedicine or telehealth kiosks
- Electronic vital signs monitoring or Marketplaces (e.g. Tele-ICU, Tele-stroke)

Therapies And Tests

- Full body CT scans
- 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 this **Policy**:

- Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including medications, nicotine patches and gum unless recommended by the United States Preventive Services Task Force (USPSTF). This also includes:
  - Counseling, except where stated in the *Coverages – Preventive Care And Wellness* section
  - Hypnosis and other therapies
  - Medications, except where stated in the *Coverages – Prescription Drugs/Medications* section
  - Nicotine patches
  - Gum

Treatment In A Federal, State, Or Governmental Entity

Except where required by **applicable law**:

- Charges **you** have no legal obligation to pay
- Charges that would not be made if **you** did not have coverage under the **Policy**

Wilderness treatment programs

- See *Educational Services* in this section.

Work Related Illness Or Injuries

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

SECTION 7 – 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 providers**.

Network Providers

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

For **you** to receive the 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 *Coverages* section.
- Urgent care – refer to the description of **emergency services** and urgent care in the *Coverages* section and to the Schedule of Benefits.
- **Network provider not reasonably available** – **You** can get **eligible health services** under **your Policy** that are provided by an **out-of-network provider** if an appropriate **network provider** is not reasonably available. **You** must ask to use the **out-of-network provider** in advance and **we** must agree. See the *How To Contact **Us** For Help* section for assistance. **We** will make a decision as soon as **your** medical condition requires but no later than 5 working days after **we** receive all of the information **we** need from **your provider**. **We** may decide not to approve **your** request. Before **we** deny the request, a **specialist** of the same or similar specialty as the **provider you** are requesting to see will review **your** request. If access is approved, **we** will pay the **out-of-network provider** at **our** usual and c**us**tomary charge or at an agreed rate. **We** will work with the **provider** so that all **you** pay is the appropriate network level **copayment**. See the *How To Contact **Us** For Help* section for assistance.
- Transplants – see the description of transplant services in the *Coverages* section

You may select a **network provider** from the provider **directory** through **our** website. See the *How To Contact **Us** For Help* section. **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**. **We** will directly pay the **network provider** for what the **Policy** owes.

Your PCP

For **you** to receive the network level of benefits, **eligible health services** must be accessed through **your PCP's** office. 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

Your PCP can provide care for obstetrical or gynecological services, or **you** can choose an OB, GYN, or OB/GYN **network provider** to provide care for those services. **You** can access an OB, GYN, or OB/GYN

without a **referral** from **your PCP**. A female has direct access to an OB, GYN or OB/GYN in addition to a PCP.

If **you** have a chronic, disabling or life-threatening **illness**, **you** can request to use a network **specialist** as **your PCP**. **Your** network **specialist** must let **us** know that the network **specialist** agrees to act as **your PCP**. **You** can contact Member Services at the toll-free number on **your** ID card for information as to how to apply for this exception.

Designation of **your** network **specialist** as **your PCP** will not be retroactive. If **your** request is denied, **you** may appeal the decision. See the attached Health Care Insurer Appeals Process and the *When **You** Disagree - Complaint Decisions And Appeal Procedures* section.

How To Choose Your PCP

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

Each covered family member is required to select a **PCP**. **You** may each select a different **PCP**. **You** must select a **PCP** for **your** covered dependent if the covered dependent is a minor or cannot choose a **PCP** on his/her own.

What Your PCP Will Do For You

Your PCP will coordinate **your** medical care or may provide treatment. **Your PCP** 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

Your PCP will give **you** a written or electronic **referral** to see other **network providers**.

You will never need a **referral** or authorization from **your PCP** to go to an OB/GYN **network provider.**

How To Change Your PCP

You may change **your PCP** at any time. **You** can call **us** at the number on **your** ID card or log in to **our** website. See the *How To Contact **Us** For Help* section to make a change.

What Happens If You Do Not Select A PCP

Because having a **PCP** is so important, **we** may choose one for **you**. **We** will notify **you** of the **PCP**'s name, address and telephone number.

Keeping A Provider You Go To Now (Continuity Of Care)

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

- The **provider you** have now is not in the network
- **You** are already a member of Imperial 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 An Out-Of-Network Provider	**When Your Provider Stops Participation With Us**
Request for approval	**You** need to complete a Transition of Coverage Request form and send it to **us**. **You** can get this form by calling the number on **your** ID card.	**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 120 days, but this may vary based on **your** condition.	Care will continue during a transitional period, usually 120 days, but this may vary based on **your** condition. 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.	

	If You Have A Disability, Acute Condition, Or Life-Threatening Condition And Your Provider Stops Participation With Imperial
Request for approval	**Your provider** should call **us** for approval to continue any care. **You** can call Member Services at the toll-free number on **your** ID card for information on continuity of care.
Length of transitional period	Care will continue during a transitional period for up to 120 days. This date is based on the date the **provider** terminated his/her participation with **us**.
How claim is paid	**Your** claim will be paid at not less than the network contract rate during the transitional period.

	If You Have A Terminal Illness And Your Provider Stops Participation With Imperial
Request for approval	**Your provider** should call **us** for approval to continue any care. **You** can call Member Services at the toll-free number on **your** ID card for information on continuity of care.
Length of transitional period	Care will continue during a transitional period of at least 120 days for up to 9 months. This date is based on the date the **provider** terminated his/her participation with **us**.
How claim is paid	**Your** claim will be paid at not less than the network contract rate during the transitional period.

	If You Are Pregnant And Have Entered Your Second Trimester And Your Provider Stops Participation With Imperial
Request for approval	**Your provider** should call **us** for approval to continue any care.
	You can call Member Services at the toll-free number on **your** ID card for information on continuity of care.
Length of transitional period	Care will continue during a 90 day transitional period through delivery, including the time required for postpartum care directly related to the delivery. This

	includes a post-delivery checkup within 6 weeks.
How claim is paid	**Your** claim will be paid at not less than the network contract rate during the transitional period.

We will authorize coverage for the transitional period only if the **provider** agrees to **our** usual terms and conditions for contracting **providers**. However, **you** will not be balance billed by the provider.

SECTION 8 – WHAT THE WE PAY AND WHAT YOU PAY

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

- **Your deductible**
- **Your copayments**
- **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 Schedule of Benefits lists how much **We** pay and how much **you** pay for each type of health care service. In general, when **you** get **eligible health services**:

- **You** pay for the entire expense up to any **deductible** limit, if applicable.
- Imperial and **you** share the expense up to any **maximum out-of-pocket limit**. **Your** share is called a **copayment**.
- **Copayments** do not accumulate to **your deductible,** but do accumulate to **your maximum out-of-pocket limit**
- Then, **We** pay 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**. See the *Definitions* section for what this term means.

Important Note – When We Pay All

We pay the entire expense for all **eligible health services** under the preventive care and wellness benefit.

Important Note – When You Pay All

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

- When **you** get a health care service or supply that is not **medically necessary**. See the *Medical Necessity Referral, And Preauthorization Requirements* section.
- When Imperial requires **preauthorization**, it was requested, **we** ref**us**ed it, and **you** get an **eligible health service** without **preauthorization**. See the *Medical Necessity Referral, And Preauthorization Requirements* section.
- When **you** get an **eligible health service** without a **referral** when **your Policy** requires a **referral**. See the *Medical Necessity Referral, And Preauthorization Requirements* section.
- When **you** get an **eligible health service** from someone who is not a **network provider**. See the *Who Provides The Care* section.

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

Special Financial Responsibility

You are responsible for the entire expense of cancelled or missed appointments.

Where Your Schedule Of Benefits Fits In

The Schedule of Benefits shows any benefit limitations that apply to **your Policy**. It also shows any out-of-pocket costs **you** are responsible for when **you** receive **eligible health services**, and any **maximum out- of-**

pocket limits that apply.

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

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

We will approve or deny a claim within 30 days of receiving the claim from **your provider**. If the claim is approved, **we** will pay the claim within 30 days of approval.

SECTION 9 – WHEN YOU DISAGREE – COMPLAINT DECISIONS AND APPEAL PROCEDURES

Internal Procedures

Your satisfaction is very important to **us**. **We** want to know **your** issues and concerns so **we** can improve our services. Reporting these will not affect **your** health care services. The following processes are available to address **your** concerns.

Call Member Services

Please contact Member Services at 1-866-906-8966 (TTY 1-800-708-59765, 711) if **you** have questions or concerns. **We** will attempt to answer **your** questions during initial contact, as most concerns can be resolved with one phone call.

Applicability/Eligibility

The internal *appeal* procedures apply to any **hospital** or medical **policy** or certificate or conversion plans, but not to accident only or disability only insurance.

An eligible grievant is:

1. A claimant*;*
2. A person *authorized* to act on behalf of the claimant. Note: Written *authorization* is not required; however, if received, **we** will accept any written expression of *authorization* without requiring specific form, language, or format;
3. In the event the claimant is unable to give consent: a *spouse*, family *member*, or the treating provider; or
4. In the event of an *expedited grievance*: the person for whom the insured has verbally given *authorization* to represent the claimant. Important: *Adverse benefit determinations* that are not *grievances* will follow standard Patient Protection and Affordable Care Act (PPACA) internal *appeals* processes.

Appeal

Claimants have the right to submit written comments, documents, records, and other information relating to the claim for benefits. Claimants have the right to review the claim file and to present evidence and testimony as part of the internal review process.

Appeals will be promptly investigated and presented to the internal *grievance* panel. A plan that is providing benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review. **We** are required to provide continued coverage pending the outcome of an *appeal*. A request for an *appeal* must be submitted within **180 days** following receipt of an *adverse benefit determination*.

You or **your** *authorized representative* may file an *appeal* by calling Member Services at **1-866-906-8966** (TTY: **1-800-708-5976, 711**) or in writing by mailing or faxing **your** *appeal* to:

Claimants should submit all documentation to us at:

Imperial Insurance Companies, Inc.,

Attn: Appeals & Grievances Department
1100 East Green Street,
Pasadena, CA 91106

Acknowledgement

Within **five business days** of receipt of a *grievance*, a written acknowledgment to the claimant or the *authorized representative* confirming receipt of the *grievance* must be delivered or deposited in the mail. When acknowledging a *grievance* filed by an *authorized representative*, the acknowledgement shall include a clear and prominent notice that health care information or medical records may be disclosed only if permitted by law.

1. The acknowledgement shall state that unless otherwise permitted under applicable law, informed consent is required and the acknowledgement shall include an informed consent form for that purpose;
2. If such disclosure is prohibited by law, health care information or medical records may be withheld from an *authorized representative*, including information contained in its resolution of the *grievance*; and
3. A *grievance* submitted by an *authorized representative* will be processed regardless of whether health care information or medical records may be disclosed to the *authorized representative* under applicable law.

Resolution Timeframes

1. All other *grievances* will be resolved and **we** will notify the claimant in writing with the *appeal* decision within the following timeframes:
    a. *Post-service appeal*: within **30 calendar days** after receipt of the claimant's request for internal *appeal*; or
    b. *Pre-service appeal*: within **30 calendar days** after receipt of the claimant's request for internal *appeal*.

The time period may be extended for an additional **30 calendar days**, making the maximum time for the entire *appeal* process **60 calendar days** if **we** provide the claimant and the claimant's *authorized representative*, if applicable, written notification of the following within the first **30 calendar days**:

a. That **we** have not resolved the appeal;
b. When our resolution of the appeal may be expected; and
c. The reason why the additional time is needed.

A claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant's claim for benefits. All comments, documents, records and other information submitted by the claimant relating to the claim for benefits, regardless of whether such information was submitted or considered in the initial *adverse benefit determination*, will be considered in the internal *appeal*.

1. The claimant will receive from **us**, as soon as possible, any new or additional evidence considered by the reviewer. **We** will give the claimant **10 calendar days** to respond to the new information before making a determination, unless the state turnaround time for response is due in less than **10 days**. If the turnaround time is less than **10 days**, the claimant will have the option of delaying the determination for a reasonable period of time to respond to the new information; or
2. The claimant will receive from **us**, as soon as possible, any new or additional medical rationale considered by the reviewer. **We** will give the claimant **10 calendar days** to respond to the new medical rationale before making a determination, unless the state turnaround time for response is

due in less than **10 days**. If turnaround time is less than 10 days, the claimant will have the option of delaying the determination for a reasonable period of time to respond to the new medical rationale.

Grievance Panel

The *grievance* panel will not include the person who made the initial determination and is not the subordinate of the original reviewer. The panel may, however, consult with the initial decision-maker. If the panel consists of at least three persons, the panel may then include no more than one subordinate of the person who made the initial determination.

The *grievance* panel will include:

1. At least one individual *authorized* to take corrective action on the *appeal*; and
2. At least one member other than the grievant, if a member is available to serve on the *grievance* panel. The *member* of the panel shall not be an employee of Imperial, to the extent possible.

When the *adverse benefit determination* is based in whole or in part on a medical judgment, the *grievance* panel will consult with a licensed health care provider with expertise in the field relating to the *appeal* and who was not consulted in connection with the original *adverse benefit determination*.

Expedited Appeal

An *expedited appeal* may be submitted orally or in writing. All necessary information, including our determination on review, will be transmitted between the claimant and us by telephone, facsimile, or other available similarly expeditious method.

An *expedited appeal* shall be resolved as expeditiously as the claimant's health condition requires but not more than **72 hours** after receipt of the *appeal*.

Due to the **72-hour** resolution timeframe, the standard requirements for notification, *grievance* panel/right to appear, and acknowledgement do not apply to *expedited appeals*.

Upon written request, we will mail or electronically mail a copy of the claimant's complete **policy** to the *authorized representative* as expeditiously as the *appeal* is handled.

Written Appeal Response

Appeal response letters shall describe, in detail, the *appeal* procedure and the notification shall include the specific reason for the denial, determination, or initiation of disenrollment. The panel's written decision to the grievant must include:

1. The disposition of and the specific reason or reasons for the decision;
2. Any corrective action taken on the *appeal*;
3. The signature of one voting *member* of the panel; and
4. A written description of position titles of panel *members* involved in making the decision.
5. If upheld or partially upheld, it is also necessary to include:
    a. A clear explanation of the decision;
    b. Reference to the specific plan provision on which the determination is based;
    c. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant 's claim for benefits;
    d. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar

criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;

e. If the *adverse benefit determination* is based on a medical necessity or *experimental treatment* or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant 's medical circumstances, or a statement that such explanation will be provided free of charge upon request;
f. Identification of medical experts whose advice was obtained on behalf of the health plan, without regard to whether the advice was relied upon in making the *adverse benefit determination*;
g. The date of service;
h. The health care provider's name;
i. The claim amount;
j. The diagnosis and procedure codes with their corresponding meanings, or an explanation that the diagnosis and/or procedure codes are available upon request;
k. The health plan's denial code with corresponding meaning; A description of any standard used, if any, in denying the claim;
l. A description of the external review procedures, if applicable;
m. The right to bring a civil action under state or federal law;
n. A copy of the form that authorizes the health plan to disclose protected health information, if applicable;
o. That assistance is available by contacting the specific Nevada Department of Insurance, if applicable; and
p. A culturally linguistic statement based upon the claimant's county or state of *residence* that provides for oral translation of the *adverse benefit determination*, if applicable.

Grievances

Basic elements of a *grievance* include:

1. The complainant is the claimant or an *authorized representative* of the claimant;
2. The submission may or may not be in writing;
3. The issue may refer to any dissatisfaction about:
    a. Imperial, including customer service *complaints* – "the person was rude to me"; "the person to whom I spoke on the phone was rude to me" or any other similar exchange;
    b. Providers with whom we have a direct or indirect contract;
        i. Lack of availability and/or accessibility of *network providers* not tied to an unresolved
        ii. benefit denial; and
        iii. Quality of care/quality of service issues;
4. Written expressions of dissatisfaction regarding quality of care/quality of service are processed as *grievances*;
5. Oral expressions of dissatisfaction regarding quality of care/quality of service are processed as *complaints*, if resolved within **24 hours**; and
6. Any of the issues listed as part of the definition of *grievance* received from the claimant or the *authorized representative* where the caller has not submitted a written request but calls us to escalate their dissatisfaction and request a verbal/oral review.

Oral quality of care or quality of service *complaints* received that are not resolved within **24 hours** are

handled as a *grievance*. If **you** make an oral *complaint* and **you** are not satisfied with the resolution of the *complaint*, **you** must file the *complaint* in writing to receive further review of the *complaint*.

You or **your** *authorized representative* may file a *grievance* by calling Member Services at 1-866-906-8966(TTY: 1-800-708-5976, TYY 711) or in writing by mailing or faxing **your** *grievance* to:

Imperial Insurance Companies, Inc.,
Attn: Appeal and Grievance Department
1100 East Green Street
Phone 1-866-906-8966
Fax Number: 1-626-521-6028

If filing a written *grievance*, please include:

- **Your** first and last name
- **Your** *member* identification number
- **Your** address and telephone number
- Details surrounding **your** concern

SECTION 10 – WHEN COVERAGE ENDS

Coverage can end for a number of reasons. This section informs **you** how and why coverage ends. The next section informs **you** when **you** may be able to continue coverage.

When Your Coverage Will End

Your coverage under this **Policy** will end if:

- This **Policy** is discontinued.
- **You** are no longer eligible for coverage including moving out of the **service area** Coverage ends 30 days after **we** notify **you** of the termination
- **You** voluntarily stop **your** coverage by notifying the Marketplace or the Plan in writing at least 14 days before the date **you** want **your** coverage to end
- **You** no longer meet the eligibility requirements of the Marketplace or the Plan including moving out of the **service area**
- **You** do not pay the required **premium** payment by the end of the grace period. Coverage ends on the last date for which the **premium** was paid or as of the date required by law
- This product is discontinued in the state, if approved by the insurance department of the state where this **Policy** was issued.
- **We** withdraw from the individual market in the state, if approved by the insurance department of the state where this **Policy** was issued.
- **We** rescind **your** coverage, as permitted under this **Policy**

When Coverage Will End For Any Dependents

Dependent coverage will end if:

- The dependent no longer eligible for coverage
- The dependent no longer meets the eligibility requirements of the Marketplace or the Plan
- The required **premium** contribution toward the cost of dependent's coverage is not made
- **Your** coverage ends for any of the reasons listed above

Notice Of Coverage Ending

The Marketplace or the Plan will send **you** notice if **your** coverage is ending. This notice will tell **you** the date that coverage ends. Coverage will end immediately on the next **premium** contribution due date following the date on which **you** no longer meet the eligibility requirements.

When We Would End Coverage

We may end **your** coverage upon 30 days written notice to **you** if **you** commit fraud or intentionally misrepresent yourself when **you** applied for or got coverage. **You** can refer to the *General Provisions – Other Things **You** Should Know* section for more information.

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

SECTION 11 – GENERAL PROVISIONS – OTHER THINGS YOU SHOULD KNOW

Administrative Provisions

How We Will Interpret This Policy

We prepared this **Policy** according to federal and state laws, as applicable. **We** will interpret the **Policy** according to these laws. Also, **you** are bound by **our** interpretation of this **Policy** when **we** administer **your** coverage, so long as **we** use reasonable discretion.

How We Administer This Policy

We apply policies and procedures **we** have 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 providers**. They are not **our** employees or agents.

Coverage And Services

Your Coverage Can Change

Sometimes things happen outside of **our** control. These are things such as natural disasters, epidemics, fire, and riots. **We** will try hard to get **you** access to the **eligible health services** that **you** need even if these things happen.

For any material modifications to **your** coverage, **we** will give **you** a 60-day notice. An example of a material modification is a reduction or elimination of benefits.

Your coverage is defined by this **Policy**. This document may have amendments or riders too. Under certain circumstances, **we** or an **applicable law** may change **your Policy**. When an emergency or epidemic is declared, **we** may modify or waive **preauthorization**, **prescription** quantity limits or **your** cost share if **you** are affected. Any modification made will be no less favorable than current requirements. Only **we** may waive a requirement of **your Policy**. No other person – including **your provider** – can do this.

Financial Sanctions Exclusions

If coverage provided under this **Policy** violates or will violate any economic or trade sanctions, the coverage will be invalid immediately. For example, **we** cannot pay for **eligible health services** if it violates a financial sanction regulation. This includes sanctions related to a person or a country under sanction by the United States, unless it is allowed under a written license from the Office of Foreign Asset Control (OFAC). **You** can find out more by visiting **Treasury.gov/resource- center/sanctions/Pages/default.aspx**.

If You Become Eligible For Medicare

If **you** have questions about Medicare, **you** can contact **your** local Social Security Administration office.

Workers' Compensation

If benefits are paid by **us** and **we** determine **you** received worker's compensation benefits for the same event, **we** have the right to recover the payment **we** made ("recover") as described under the *When **You** Are Injured By A Third-Party* section in **your Policy**. **We** will seek to recover the payments from **you**.

These recovery rights will be applied even though:

- The workers' compensation benefits are in dispute or are made by means of settlement or compromise
- No final determination is made that bodily **injury** or **illness** was sustained in the course of, or resulted from, **your** employment
- The amount of workers' compensation due to medical or health care is not agreed upon or defined by **you** or the workers' compensation carrier
- The medical or health care benefits are specifically excluded from the workers' compensation settlement or compromise

You agree that **you** will notify **us** of any workers' compensation claim **you** make, and that **you** will reimburse **us** as described above. If benefits are paid under this **Policy** and **you** or any covered dependent recover payment or benefits from a responsible party, **we** have a right to recover from **you** or any covered dependent an amount equal to the amount **we** paid.

Legal Action

You must complete the internal appeal process before **you** take any legal action against **us** for any expense or bill. See the *When **You** Disagree - Complaint Decisions And Appeal Procedures* section in **your Policy and the attached Health Care Insurer Appeals Process**. **You** cannot take any action until 60 days after **we** receive the written submission of claim.

No legal action can be brought to recover payment under any benefit after 3 years from the deadline for filing claims.

Benefits Not Transferable

Only **you** and **your** covered dependents may receive benefits under this **Policy**.

Following The Law

If, on the **Policy**'s effective date, language in the **Policy** is different from a law that applies to it, the **Policy** will follow **applicable federal or Nevada law**.

When You Are No Longer The Subscriber

If **you** are no longer the subscriber and the **Policy** was not cancelled, **your** covered spouse, civil union partner, domestic partner will become the subscriber. For a covered dependent child, the parent or legal guardian who is also covered under the **Policy** will become the subscriber. If there is no subscriber at the end of a **premium** period, the **Policy** will be cancelled.

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 subscriber. As a parent or legal guardian, the subscriber has subscribed on behalf of the child for the benefits described in this **Policy**. It is the subscriber's responsibility to make sure the child fulfills 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 covered by another Imperial individual coverage **Policy**:

- **You** have a right only to benefits of the **Policy** with the better benefits

- **We** will refund any **premium** charges **you** paid for the **Policy** with the lesser benefits during the time **you** were covered by both plans

If, while covered under this **Policy**, **you** are covered under an Imperial group plan:

- **You** have a right only to benefits of the group plan
- **We** will refund any **premium** charges **you** paid for the individual **Policy** during the time **you** were covered by both plans

Physical Examinations And Evaluations

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

Records Of Expenses

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

Things that would be important to keep are:

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

Honest Mistakes And Intentional Deception

Honest Mistakes

You may make an honest mistake when **you** share facts with **us**. When **we** discover a mistake, **we** may make a fair change in **premium** contribution or in **your** coverage. If **we** do, **we** will tell **you** what the mistake was. **We** will not make a change if the mistake happened more than 2 years before **we** learned of it.

We also will not use any statement made to void, cancel or non-renew **your** coverage or reduce benefits unless it is in a written enrollment application, signed by the contract holder and furnished to **you**.

Intentional Deception

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

- Loss of coverage, starting at some time in the past
- Loss of coverage going forward
- Denial of benefits
- Recovery of amounts **we** already paid

We also may report fraud to criminal authorities.

You have special rights if **you** lose coverage:

- **We** will give **you** 30 days advanced written notice of any loss of coverage
- **You** have the right to an Imperial appeal
- **You** have the right to a third-party review conducted by an independent review organization

In the absence of fraud, any statement made on **your** application for coverage is considered a representation and not a warranty.

Financial Issues

Assignment Of Benefits

When **you** see a **network provider**, the **network provider** 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. To the extent allowed by **applicable law**, **we** will not accept an assignment to an **out-of-network provider**.

Recovery Of Overpayments

In certain instances, **we** may overpay for **eligible health services** or pay for something that this **Policy** does not cover. If **we** do, **we** can require the person **we** paid – **you** or **your provider** – to return what **we** paid. If **we** do not seek recovery of the overpayment, **we** have the right to reduce any future benefit payments by the amount **we** paid by mistake.

Your Health Information

We will protect **your** health information. **We** 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 **us** at the number on **your** ID card. When **you** accept coverage under this **Policy**, **you** agree to let **your providers** share **your** information with **us**. **We** will need information about **your** physical and mental condition and care.

Other Items

We will not deny a claim, refuse to issue or cancel a **Policy** of health insurance solely because the claim involves an act that constitutes domestic violence pursuant to NRS 695C.203, or because **you** were the victim of such an act of domestic violence, regardless of whether **you** contributed to any loss or **injury**.

We will not deny a claim, refuse to issue or cancel a **Policy** of health insurance solely because the claim involves an **injury** sustained by **you** as a consequence of being intoxicated or under the influence of a controlled substance or because **you** made a claim involving an **injury** sustained by **you** as a consequence of being intoxicated or under the influence of a controlled substance, except in the case of a felony.

SECTION 12 – DEFINITIONS

Imperial
Imperial Insurance Companies, Inc., is the HMO contracted to pay for your covered benefits.

Adverse (Benefit) Determination
A determination by a health carrier or utilization review organization that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for the service is therefore denied, reduced or terminated.

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

Applicable Law
All federal, state and local laws, as passed or issued, that apply to topics covered by this **Policy**. These may change over time.

Behavioral Health Provider
A **health professional** licensed or certified to provide diagnostic and/or therapeutic services for **mental health disorders** and **substance related disorders** under the laws of the state where they practice.

Biomarker
- means a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes or pharmacologic responses to a specific therapeutic intervention.
- includes gene mutations or protein expression.

Brand-Name Prescription Drug
An FDA-approved **prescription drug** marketed with a specific name or trademark name by the company that manufactures it, usually by the company which develops and patents it.

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

Clinical Utility
Means the test result provides information that is used in the formulation of a treatment or monitoring strategy that informs a patient's outcome and impacts the clinical decision. The most appropriate test may include both information that is actionable and some information that cannot be immediately used in the formulation of a clinical decision.

Copay, Copayment
The specific dollar amount **you** have to pay for a health care service listed in the Schedule of Benefits.

Consensus Statements

Means statements that:

- are developed by an independent, multidisciplinary panel of experts using a transparent methodology and reporting structure that includes a conflict-of-interest policy.
- are based on the best available evidence for the purpose of optimizing clinical care outcomes.
- are aimed at specific clinical circumstances.

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

For **Policy'**s that include a **deductible**, this is the amount **you** pay for **eligible health services** per year before your **Policy** starts to pay as listed in the Schedule of Benefits.

Dentist

A **health professional** trained and licensed to perform dental work under the **applicable laws** of the state where they practice.

Dental Provider

A **physician**, **health professional**, **dentist**, specialty **dentist**, dental therapist, dental hygienist, person, or facility, licensed or certified by
applicable law to provide **you** with dental care services.

Detoxification

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

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

This can be done by metabolic or other means determined by a **physician** or a nurse practitioner working within the scope of his/her license. The process must keep the physiological risk to the patient at a minimum. If it takes place in a facility, the facility must meet any applicable licensing standards established by the state in which it is located.

Directory

The list of **network providers** for **your Policy**. The most up-to-date **directory** for **your Policy** appears on **our** website. See the *How To Contact **Us** For Help* section. When searching for **providers**:

- Make sure **you** are searching for **providers** that participate in **your** specific plan

- Remember, some **network providers** may only be considered **network providers** for certain Imperial plans
- Search under dental plans for network **dental providers**

Drug Guide

A list of **prescription drugs** and OTC drugs and devices established by **us** or an affiliate provides coverage, approves payment and encourages or offers incentives. It does not include all **prescription drugs** and OTC drugs and devices. This list can be reviewed and changed by **us** or an affiliate. A copy of the **drug guide** is available at **your** request, or **you** can find it on **our** website. See the *How To Contact **Us** For Help* section.

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 the subscriber's coverage begins under this **Policy**. The date dependents' coverage begins under this **Policy** as noted in **our** records.

Eligible Health Services

The health care services and supplies listed as **covered benefits** in the *Coverages* section. Eligible health services may have limits. See the Schedule of Benefits.

Emergency Medical Condition

A recent and severe medical condition that would lead a reasonably prudent person to reasonably believe that the condition, **illness**, or **injury** is of a severe nature and that if **you** do not get immediate medical care it could result in:

- Placing **your** health in serious danger
- Serious loss to bodily function
- Serious loss of function to a body part or organ
- Serious jeopardy to the health of the fetus
- Serious disfigurement

Emergency Services

Treatment given in a **hospital's** emergency room, freestanding emergency facility, or comparable emergency facility for an **emergency medical condition**. This includes evaluation of, and treatment to stabilize, an **emergency medical condition**.

Experimental Or Investigational

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

- There is not enough outcome data available from controlled clinical trials published in the peer-reviewed literature to validate its safety and effectiveness for the **illness** or **injury** involved.
- The needed approval by the FDA has not been given for marketing.

- A national medical or dental society or regulatory agency has stated in writing that it is **experimental or investigational** or suitable mainly for research purposes.
- It is the subject of a Phase I, Phase II or the experimental or research arm of a Phase III clinical trial. These terms have the meanings given by regulations and other official actions and publications of the FDA and Department of Health and Human Services.
- Written protocols or a written consent form used by a facility **provider** stating it is **experimental or investigational**.
- It is provided or performed in a special setting for research purposes.

Generic Prescription Drug

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

- Dosage
- Safety
- Strength
- Quality
- Performance

Gestational Carrier

An adult woman who is not an intended parent and who enters into a gestational agreement to bear a child conceived using the gametes of other persons and not her own.

Health Professional

A person who is licensed, certified or otherwise authorized by **applicable 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 law** 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**.

Hospice Care

Supportive care given to people in the final phase of a **terminal illness** with a focus on comfort and quality of life, rather than cure.

Hospice Care Agency

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

Hospice Care Program

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

Hospice Facility
An institution specifically licensed, certified or otherwise authorized by **applicable law** to provide hospice care**.**

Hospital
An institution licensed as a **hospital** by **applicable law**.

Hospital does not include a:
- Convalescent facility
- Rest facility
- Nursing facility
- Facility for the aged
- **Psychiatric hospital**
- **Residential treatment facility** for behavioral health
- Extended care facility
- Intermediate care facility
- **Skilled nursing facility**

Illness
Poor health resulting from disease of the body or mind.

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

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

Intensive Outpatient Program (IOP)
Services designed to address a **mental health disorder** or **substance related disorder** issue and may include group, individual, family or multi-family group psychotherapy, psycho-educational services, and adjunctive services such as medication monitoring. Services must be **medically necessary** and provided by a **behavioral health provider** with the appropriate license or credentials.

Jaw Joint Disorder
This is:
- A Temporomandibular Joint (TMJ) dysfunction or any similar disorder of the jaw joint
- A Myofascial Pain Dysfunction (MPD) of the jaw

- Any similar disorder in the relationship between the jaw joint and the related muscles and nerves

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

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

Maximum Out-Of-Pocket Limit
This is the most **you** will pay per year in **copayments** and any **deductible**, if one applies, for **eligible health services** as listed in the Schedule of Benefits.

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

- In accordance with generally accepted standards of medical practice
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness**, **injury** or disease
- Not primarily for the convenience of the patient, **physician** or other health care **provider**
- Not more costly than an alternative service or sequence of services at least as likely to produce the same benefit or diagnostic results as to the diagnosis or treatment of that patient's **illness**, **injury** or disease

Generally accepted standards of medical practice means:

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

Mental Health Disorder
Mental health disorders are defined in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM). The DSM is a book published by the American Psychiatric Association. It describes all recognized **mental health disorders**. In general, a **mental health disorder** is a serious disturbance in a person's thought process, emotions or behavior that causes problems in mental functioning. **Mental health disorders** are often connected to significant distress or disability in social, work or other important activities.

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

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

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

Nationally Recognized Clinical Practice Guidelines

Means evidence-based clinical practice guidelines that both:

- are developed by independent organizations or medical professional societies using a transparent methodology and reporting structure and a conflict-of-interest policy.
- establish standards of care that are informed by a systematic review of evidence and an assessment of the benefits and costs of alternative care options that includes recommendations intended to optimize patient care.

Negotiated Charge

For health coverage, this is either*:*

- The amount a **network provider** has agreed to accept, or
- The amount **we** agree to pay directly to a **network provider** or third-party vendor (including any administrative fee in the amount paid)

for providing services, **prescription drugs** or supplies to **you**. This does not include **prescription drug** services from a **network pharmacy**.

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

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

Some of these arrangements are called:

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

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

For **prescription drug** services from a **network pharmacy***:*
The amount **we** established for each **prescription drug** obtained from a **network pharmacy** under this **Policy**. This **negotiated charge** may reflect amounts **we** agreed to pay directly to the **network pharmacy** or to a third-party vendor for the **prescription drug**, and may include an additional service or risk charge set by **us**.

We may receive or pay additional amounts from, or to, third parties underprice guarantees. These amounts may 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**.

Non-Preferred Drug
A **prescription drug** or device that may have a higher out-of- pocket cost than a **preferred drug**.

Out-Of-Network Provider
A **provider** who is not a **network provider** or a **network provider** that is seen without a **referral**.

Partial Hospitalization Treatment
Services must be **medically necessary** and provided by a **behavioral health provider** with the appropriate license or credentials. Services are designed to address a **mental health disorder** or **substance related disorders** issue and may include:

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

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

Pharmacy
A place where **prescription drugs** are legally dispensed. This can be a **retail**, **mail order** or **specialty pharmacy**.

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

Preauthorization, Preauthorize
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 may have a lower out-of-pocket cost than a **non-preferred drug**.

Premium
The amount **you** are required to pay to **us** for **your** coverage.

Prescriber
Any **provider** acting within the scope of his/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
An FDA approved drug or biological which can only be dispensed by **prescription**.

Primary Care Physician (PCP)
A **physician** who:

- The **directory** lists as a **PCP** and 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
- Initiates **referrals** for **specialist** care
- 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 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 or certified as a **psychiatric hospital** by **applicable law** to provide a program for the diagnosis, evaluation and treatment of alcoholism, drug abuse, **mental health disorders** (including **substance related disorders**) or mental **illnesses**.

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

R.N.
A registered nurse.

Referral
For plans that require one, this is a written or electronic authorization made by **your PCP** to direct **you** to a **network provider** for **medically necessary** services and supplies.

Residential Treatment Facility (Mental Health Disorders)
An institution specifically licensed as a **residential treatment facility** by **applicable law** to provide for mental health residential treatment programs. And is credentialed by **us** or is accredited by one of the following agencies, commissions or committees for the services being provided:

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

- The Council on Accreditation (COA)

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

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

Residential Treatment Facility (Substance Related Disorders)

An institution specifically licensed as a **residential treatment facility** by **applicable law** to provide for **substance related disorders** residential treatment programs and is credentialed by **us** or accredited by one of the following agencies, commissions or committees for the services being provided:

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

In addition to the above requirements, an institution must meet the following for Chemical Dependence Residential Treatment Programs:

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

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

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

Retail Pharmacy

A community **pharmacy** that dispenses outpatient **prescription drugs**.

Room And Board

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

Semi-Private Room Rate

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

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 law** to provide skilled nursing care.

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

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 health disorders** or **substance related disorders**.

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 Drug
An FDA-approved **prescription drug** that typically has a higher cost and requires special handling, special storage or monitoring and may include things such as oral, topical, inhaled and injected routes of administration.

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

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

Step Therapy
A form of **preauthorization** where **you** must try one or more prerequisite drug(s) before a step therapy drug is covered. The prerequisite drugs have FDA approval, may cost less and treat the same condition. If **you** do not try the appropriate prerequisite drug first, **you** may need to pay full cost for the step therapy drug.

Substance Related Disorder
This is a physical or psychological dependency, or both, on a controlled substance or alcohol agent. These are defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association. This term does not include conditions that **you** cannot attribute to a **mental health disorder** that are a focus of attention or treatment or an addiction to nicotine products, food or caffeine intoxication.

Surgery Center
A facility specifically licensed as a freestanding ambulatory surgical facility by **applicable law** 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, Surgical Procedure

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

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

It also includes:

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

Teledentistry

A health professional acting under the delegation and supervision of a **dentist**, acting within the scope of the **dentist**'s or **health professional's** license or certification to a patient at a different physical location than the **dentist** or **health professional** using telecommunications or information technology.

Telehealth

A health service, other than a **telemedicine** medical service, delivered by a **health professional** licensed, certified or otherwise entitled to practice in the State of Nevada and acting within the scope of the **health professional's** license, certification or entitlement to a patient at a different physical location than the **health professional** using telecommunications or information technology.

Telemedicine

A health care service delivered by a **physician** licensed in the State of Nevada, or a **health professional** acting under the delegation and supervision of a **physician** licensed in the State of Nevada and acting within the scope of the **physician** or **health professional's** license to a patient at a different physical location than the **physician** or **health professional** using telecommunications or information technology.

Terminal Illness

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

Urgent Care Facility

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

- Drug store
- **Pharmacy**
- Retail store
- Supermarket

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

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