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# HEALTH MAINTENANCE ORGANIZATION (HMO)

## SCHEDULE OF BENEFITS

## Imperial Preferred Gold Zero Limited CSR

IMPERIAL INSURANCE COMPANIES

# SCHEDULE OF BENEFITS

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

### How To Read Your Schedule of Benefits

- **You** must pay any **copayments** if they apply.
- **You** must pay the full amount of any health care service **you** get that is not a **covered benefit**.
- This plan has limits for some **covered benefits**. For example, these could be:
  - Visit limits
  - Day limits
  - Dollar limits

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

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

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

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

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

## How To Contact Us For Help

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

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

Imperial Insurance Companies HMO Evidence of Coverage (EOC) provides the coverage described in this Schedule of Benefits**.** This schedule replaces any Schedule of Benefits previously in use. Keep it with **your** EOC.

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

### Maximum Out-Of-Pocket Limit

| Maximum Out-Of-Pocket Limit | In-Network |
|---|---|
| Individual | $9,200 |
| Family | $18,400 |

## General Coverage Provisions

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

### Maximum Out-Of-Pocket Limit Provisions

- **Eligible health services** that are subject to the **maximum out-of-pocket limit** may include **covered benefits** provided under the medical plan and the outpatient **prescription drug** plan.
- This plan may have an individual and family **maximum out-of-pocket limit**. As to the individual **maximum out-of-pocket limit**, each of **you** must meet **your maximum out-of-pocket limit** separately.

### Individual Maximum Out-Of-Pocket Limit

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

### Family Maximum Out-Of-Pocket Limit

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

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

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

If the **maximum out-of-pocket limit** does not apply to a **covered benefit**, **your** cost share for that **covered benefit** will not count toward satisfying the **maximum out-of-pocket limit** amount.

Certain costs that **you** incur do not apply toward the **maximum out-of-pocket limit**. These include:

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

### Your Financial Responsibility And Decisions Regarding Benefits

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

## Eligible Health Services

## 1. Preventive Care And Wellness

| Description | In-Network |
|---|---|
| Preventive care and wellness | $0 **copay** |

Preventive Care And Wellness includes:

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

### Preventive Care And Wellness Benefit Limits

**Routine Physical Exams**

- Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents

### Preventive Care Immunizations

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

### Well Woman Preventive Visits

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

**Preventive Screening And Counseling Services**

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

### Routine Cancer Screenings

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

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

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

### Prenatal Care Services

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

### Comprehensive Lactation Support And Counseling Services

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

### Breast Feeding Durable Medical Equipment

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

### Family Planning Services

See the *Family Planning Services* section of the policy for more information on coverage for Family Planning Services.

## 2. Physicians And Other Health Professionals

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

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

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

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

### Specialist Office Visits

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

| | |
|---|---|
| Office hours visit (non-surgical) | $40 **copay**, no **deductible** applies |
| **Telemedicine** or **telehealth** consultation by a **Specialist** | $40 **copay**, no **deductible** applies |

**Allergy Testing And Treatment**

| Description | In-Network |
|---|---|
| Performed at a **physician** or **specialist** office visit | 50% percentage copayment, no **deductible** applies |

**Immunizations That Are Not Considered Preventive Care**

| Description | In-Network |
|---|---|
| Immunizations that are not considered preventive care | 50% percentage copayment after **deductible** |

**Medical Injectables**

| Description | In-Network |
|---|---|
| Performed at a **physician** or **specialist** office | 50% percentage copayment after **deductible** |

**Physician Surgical Services**

| Description | In-Network |
|---|---|
| Inpatient surgical services | 50% percentage copayment, no **deductible** applies |
| Performed at a **physician** or **specialist** office | 50% percentage copayment, no **deductible** applies |

## 3. Inpatient and Outpatient Hospital Services

**Hospital Care**

| Description | In-Network |
|---|---|
| Inpatient **hospital** | 50% percentage copayment, no **deductible** applies |

**Specialty Prescription Drugs**

| Description | In-Network |
|---|---|
| Performed in a **physician** office, outpatient department of a **hospital**, other outpatient facility that is not a **hospital**, or in the home | 50% percentage copayment after **deductible** |

## 4. Extended Care Services

**Outpatient Surgery**

| Description | In-Network |
|---|---|
| Physician/Surgical services performed in **hospital** outpatient department or other facility | 50% percentage copayment, no **deductible** applies |
| Outpatient Facility Fee (e.g., Ambulatory Surgical Center) | 50% percentage copayment, no **deductible** applies |

**Home Health Care**

| Description | In-Network |
|---|---|
| Outpatient | 50% percentage copayment, no **deductible** applies |

| | |
|---|---|
| Visit limit per year | Coverage is limited to 60 visits per calendar year |

**IMPORTANT NOTE:**

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

**Hospice Care**

| Description | In-Network |
|---|---|
| Inpatient services | 50% percentage copayment, no **deductible** applies |
| Outpatient services | 50% percentage copayment, no **deductible** applies |

**Skilled Nursing Facility**

| Description | In-Network |
|---|---|
| Inpatient facility | 50% percentage copayment, no **deductible** applies |
| Day limit per year | Coverage is limited to 25 days per calendar year |

## 5. Emergency Services

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

| Description | In-Network |
|---|---|
| **Hospital** emergency room (or comparable facility/freestanding emergency medical care facility) | 50% percentage copayment, no **deductible** applies |
| Non-emergency care in a **hospital** emergency room (or comparable facility/freestanding emergency medical care facility) | Not covered |

**IMPORTANT NOTE:**

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

## 6. Urgent Care Services

| Description | In-Network |
|---|---|
| Urgent medical care<br>at a free standing facility that is not a **hospital** | $75 **copay**, no **deductible** applies |
| Non-urgent use of urgent care **provider**<br>at a free standing facility that is not a **hospital** | Not covered |

## 7. Pregnancy and Maternity Care

### Family Planning Services - Other

**Voluntary Sterilization for Males**

| Description | In-Network |
|---|---|
| Inpatient | 50% percentage copayment after **deductible** |
| Outpatient | 50% percentage copayment after **deductible** |

### Maternity And Related Newborn Care

**Prenatal and Postnatal Care Services**

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

**Delivery and Maternity Care Services**

| Description | In-Network |
|---|---|
| Inpatient and newborn care services and supplies | 50% percentage copayment, no **deductible** applies |
| Well Baby Visits and Care | $0 **copay** no **deductible** applies |

**IMPORTANT NOTE:**

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

## 8. Pediatric

### Pediatric Vision Care

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

**Routine Vision Exams (Including Refraction)**

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

**Pediatric Vision Care Services And Supplies**

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

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

**Limits**

| Description | Limit |
|---|---|
| Number of eyeglass frames per year | One set of eyeglass frames |

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

**IMPORTANT NOTE:**

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

### Pediatric Dental Care

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

| Description | In-Network |
|---|---|
| Diagnostic and Preventive Services | 0% percentage copayment, no **deductible** applies |
| Basic Services | 50% percentage copayment, no **deductible** applies |
| Major Services | 50% percentage copayment, no **deductible** applies |
| Medically Necessary Orthodontic Services | 50% percentage copayment, no **deductible** applies |

- 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).
- Major Services
    - 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.
    - 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. Exam and cleaning limitations:
    i) We will pay for oral examinations (except after hours exams and exams for observation) and routine cleanings, including scaling in presence of generalized moderate or severe gingival inflammation (or any combination thereof) no more than once every six (6) months. Periodontal maintenance are limited to four (4) times in a 12-month period. Up to four (4) periodontal maintenance procedures and up to two (2) routine cleanings, including scaling in presence of generalized moderate or severe gingival inflammation (or any combination thereof) not to exceed four (4) procedures in a 12-month period. See note on additional Benefits during pregnancy.
    ii) A full mouth debridement is allowed once in a lifetime, when the Enrollee has no history of prophylaxis, scaling and root planing, periodontal surgery, or periodontal maintenance procedures within three years, and counts toward the cleaning frequency in the year provided.
    iii) Note that periodontal maintenance, Procedure Codes that include periodontal maintenance, and full mouth debridement are covered as a Basic Benefit, and routine cleanings including scaling in presence of generalized moderate or severe gingival inflammation are covered as a Diagnostic and Preventive Benefit. Periodontal maintenance is only covered when performed following active periodontal therapy.
    iv) Caries risk assessments are allowed once in 12 months.
    v) 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:
    i) We will limit the total reimbursable amount to the Provider's Accepted Fee for a comprehensive intraoral series when the fees for any combination of intraoral images in a single treatment series meet or exceed the Accepted Fee for a comprehensive intraoral series.
    ii) 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 comprehensive intraoral series.
    iii) If a panoramic image is taken in conjunction with an intraoral comprehensive series, We consider the panoramic image to be included in the comprehensive series.
    iv) A comprehensive intraoral series and panoramic image are each limited to once every 60 months.
    v) 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.
    vi) Image capture procedures are not separately allowable services.
7. The fee for pulp vitality tests are included in the fee for any definitive treatment performed on the same date.
8. Topical application of fluoride solutions is limited to twice within a 12-month period.
9. A distal shoe space maintainer - fixed - unilateral is limited to children 8 and younger and is limited to once per quadrant per lifetime. A separate/additional space maintainer can be allowed after the removal of a unilateral distal shoe. 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.
10. Sealants are limited as follows:
    i) once in 36 months to permanent molars if they are without caries (decay) or restorations on the occlusal surface.
    ii) repair or replacement of a Sealant on any tooth within 24 months of its application is included in the fee for the original placement.
11. Preventive resin restorations in a moderate to high risk caries risk patient - permanent tooth are limited to once per tooth in 36 months.
12. 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.
13. We will not cover replacement of an amalgam or resin-based composite restorations (fillings) within 24 months of treatment if the service is provided by the same Provider/Provider office. Prefabricated crowns are limited to once per Enrollee per

tooth in any 60-month period. Replacement restorations within 24 months are included in the fee for the original restoration.

14. Protective restorations (sedative fillings) are allowed 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.
15. Prefabricated stainless steel crowns are allowed on baby (deciduous) teeth and permanent teeth through age 14. Replacement restorations within 24 months are included in the fee for the original restoration.
16. Therapeutic pulpotomy is limited to baby (deciduous) teeth only; an allowance for an emergency palliative treatment is made when performed on permanent teeth.
17. Pulpal therapy (resorbable filling) is limited to once in a lifetime and to primary incisor teeth for Enrollees up to age 6 and for primary molars and cuspids up to age 11. Retreatment of root canal therapy by the same Provider/Provider office within 24 months is considered part of the original procedure.
18. Apexification is only benefited on permanent teeth with incomplete root canal development or for the repair of a perforation.
19. Retreatment of apical surgery by the same Provider/Provider office within 24 months is considered part of the original procedure.
20. Fees for additional pins on the same tooth on the same date are considered a component of the initial pin placement.
21. Palliative treatment is covered per visit, not per tooth, and the fee for palliative treatment provided in conjunction with any procedures other than images or select Diagnostic procedures is considered included in the fee for the definitive treatment.
22. Periodontal limitations:
    - i) Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-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.
    - ii) Periodontal surgery in the same quadrant is limited to once in every 36-month period and includes any surgical re-entry or scaling and root planing performed within 36 months by the same dentist/dental office.
    - iii) Periodontal services, including graft procedures 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.
    - iv) Bone grafts are not benefited in conjunction with soft tissue grafts in the same surgical area.
    - v) Periodontal surgery is subject to a 30 day wait following periodontal scaling and root planing in the same quadrant.
    - vi) 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.

vii) When implant procedures are a covered Benefit, scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure is covered as a Basic Benefit and are limited to once in a 24-month period.

23. Collection and application of autologous blood concentrate product are limited to once every 36 months.
24. Crowns and Inlays/Onlays are covered not more often than once in any 60-month period except when We determine the existing Crown or Inlay/Onlay is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues. Services will only be allowed on teeth that are developmentally mature.
25. Core buildup, including any pins, is covered not more than once in any 60-month period.
26. Prefabricated post and core, in addition to crown is covered once per tooth every 60-month period.
27. Resin infiltration of incipient smooth surface lesions is covered once in any 36-month period.
28. When allowed within six (6) months of a restoration, the Benefit for a Crown, Inlay/Onlay or fixed prosthodontic service will be reduced by the Benefit paid for the restoration.
29. Prosthodontic appliances, implants and/or implant supported prosthetics (except for implant/abutment supported removable dentures) that were provided under any Delta Dental 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 and/or implant supported prosthesis not provided under a Delta Dental program will be made if We determine it is unsatisfactory and cannot be made satisfactory. Services will only be allowed on teeth that are developmentally mature. Diagnostic and treatment facilitating aids for implants are considered a part of, and included in, the fees for the definitive treatment. Our payment for implant removal is limited to one (1) for each implant within a 60-month period whether provided under Delta Dental or any other dental care plan.
30. Debridement and/or osseous contouring of a peri-implant defect, or defects surrounding a single implant, and includes surface cleaning of the exposed implant surface, including flap entry and closure is allowed once every 60-month period.
31. An implant is a covered procedure of the plan only if determined to be a dental necessity. If an arch can be restored with a standard prosthesis or restoration, no Benefits will be allowed for the individual implant or implant procedures. Only the second phase of treatment (the prosthodontic phase-placing of the implant crown, bridge denture or partial denture) may be subject to the alternate Benefit provision of the plan.

32. When a posterior fixed bridge and a removable partial denture are placed in the same arch in the same treatment episode, only the partial denture will be a Benefit.
33. Recementation of Crowns, Inlays/Onlays or bridges is included in the fee for the Crown,Inlay/Onlay or bridge when performed by the same Provider/Provider office within six (6) months of the initial placement.
34. The initial installation of a prosthodontic appliance and/or implants is not a Benefit unless the prosthodontic appliance and/or implant, bridge or denture is made necessary by natural, permanent teeth extraction occurring during a time the Enrollee was under a Delta Dental plan.
35. 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.
    i) Denture rebase is limited to one (1) per arch in a 36-month period and includes any relining and adjustments for six (6) months following placement.
    ii) 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, relining is limited to one (1) per arch in a 36-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, relining is limited to one (1) per arch in a 36-month period.
    iii) Tissue conditioning is not allowed as a separate Benefit when performed on the same day as a denture reline or rebase service.
36. Occlusal guards are covered by report for Enrollees age 13 or older when the purpose of the occlusal guard is for the treatment of bruxism or diagnoses other than temporomandibular joint dysfunction (TMJD). Occlusal guards are limited to one (1) per 12 consecutive month period. We will not cover the repair or replacement of any appliances for Night Guard/Occlusal Guard. Adjustment of an occlusal guard is allowed once in 12 months following six months from initial placement.
37. Limitations on Orthodontic Services:
    i) 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 a prior authorization is obtained.
    ii) 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.
    iii) 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.

iv) 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.

v) 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.

vi) Comprehensive orthodontic treatment includes the replacement, repair and removal of brackets, bands and arch wires by the original Provider.

vii) 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.

viii) 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.

ix) All necessary procedures that may affect orthodontic treatment shall be completed before orthodontic treatment is considered.

x) 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.

xi) 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.

xii) 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.

xiii) The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered Benefit.

38. 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.
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. maxillofacial prosthetics.
5. 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). Provisional and/or temporary restorations are not separately payable procedures and are included in the fee for completed service.
6. 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 provided to children for medically diagnosed congenital defects or birth abnormalities.
7. treatment to stabilize teeth, 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, periodontal splinting, or complete occlusal adjustments.
8. any Single Procedure provided prior to the date the Enrollee became eligible for services under this plan.
9. prescribed drugs, medication, pain killers, antimicrobial agents, or experimental/investigational procedures.
10. 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. Local anesthesia and regional/or trigeminal bloc anesthesia are not separately payable procedures.

11. extraoral grafts (grafting of tissues from outside the mouth to oral tissues).
12. laboratory processed crowns for teeth that are not developmentally mature.
13. endodontic endosseous implants.
14. indirectly fabricated resin-based Inlays/Onlays.
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 or implant, 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 Delta Dental.The extraction of a third molar (wisdom tooth) will not qualify under the above. Any such denture or fixed bridge must include the replacement of the extracted tooth or teeth.
24. services for any disturbance of the temporomandibular (jaw) joints (TMJ) or associated musculature, nerves and other tissues.
25. services for Orthodontic treatment (treatment of malocclusion of teeth and/or jaws) except medically necessary Orthodontics provided a prior authorization is obtained.
26. missed and/or cancelled appointments.
27. actions taken to schedule and assure compliance with patient appointments are inclusive with office operations and are not a separately payable service.

28. the fees for care coordination are considered inclusive in overall patient management and are not a separately payable service.
29. dental case management motivational interviewing and patient education to improve oral health literacy.
30. non-ionizing diagnostic procedure capable of quantifying, monitoring and recording changes in structure of enamel, dentin, and cementum.
31. extra-oral – 2D projection radiographic image and extra-oral posterior dental radiographic image.
32. diabetes testing.
33. corticotomy (specialized oral surgery procedure associated with orthodontics).
34. antigen or antibody testing.
35. counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use.

## 9. Specific Therapies and Tests

### Outpatient Diagnostic Testing

| Description | In-Network |
|---|---|
| Diagnostic Complex Imaging Services | 50% percentage copayment, no **deductible** applies |
| Diagnostic Lab Work | 50% percentage copayment, no **deductible** applies |
| Diagnostic Radiological Services (x-rays) | 50% percentage copayment, no **deductible** applies |

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

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

### Outpatient Therapies

#### Chemotherapy

| Description | In-Network |
|---|---|
| Chemotherapy | 50% percentage copayment, no **deductible** applies |

#### Outpatient Infusion Therapy

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

| | |
|---|---|
| Performed in a **physician** office, person's home, outpatient facility, or outpatient department of a hospital | 50% percentage copayment, no **deductible** applies |

**Radiation Therapy (Therapeutic Radiology)**

| Description | In-Network |
|---|---|
| Radiation therapy | 50% percentage copayment, no **deductible** applies |

### Short-Term Cardiac And Pulmonary Rehabilitation Services

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

| Description | In-Network |
|---|---|
| Cardiac and pulmonary rehabilitation | 50% percentage copayment, no **deductible** applies |

### Short-Term Rehabilitation Therapy Services

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

**Outpatient Physical Therapy**

| Description | In-Network |
|---|---|
| Physical Therapy (PT) | $20 **copay**, no **deductible** applies |
| Visit limit per year | Coverage is limited to 35 visits per calendar year PT, OT, ST and Chiro combined |

**Outpatient Occupational Therapy**

| Description | In-Network |
|---|---|
| Occupational Therapy (OT) | $20 **copay**, no **deductible** applies |
| Visit limit per year | Coverage is limited to 35 visits per calendar year PT, OT, ST and Chiro combined |

**Outpatient Speech Therapy**

| Description | In-Network |
|---|---|
| Speech Therapy (ST) | $20 **copay**, no **deductible** applies |
| Visit limit per year | Coverage is limited to 35 visits per calendar year PT, OT, ST and Chiro combined |

**Inpatient And Outpatient Treatment For Acquired Brain Injury**

| Description | In-Network Coverage |
|---|---|
| Inpatient and outpatient treatment for acquired brain injury | 50% percentage copayment after **deductible** |
| Visit limit per year | None |

**Chiropractic**

| Description | In-Network |
|---|---|
| Spinal manipulation (Chiro) | 50% percentage copayment, no **deductible** applies |
| Visit limit per year | Coverage is limited to 35 visits per calendar year PT, OT, ST and Chiro combined |

**Habilitation Therapy Services**

| Description | In-Network |
|---|---|
| Physical, occupational, and speech therapies | 50% percentage copayment, no **deductible** applies |
| Visit limit per year | Coverage is limited to 35 visits per calendar year PT, OT, ST and Chiro combined. Does not apply to mental health, including autism. |

## 10. Other Services and Conditions

**Ambulance Service**

| Description | In-Network |
|---|---|
| Emergency **ambulance** | 50% percentage copayment, no **deductible** applies |
| Non-emergency **ambulance** | 50% percentage copayment, no **deductible** applies |

**IMPORTANT NOTE:**

- **Out-of-network providers** do not have a contract with **us**. **We** will pay the **provider** at **our** usual and customary rate or at an agreed rate charge. The **provider** may not accept payment of **your** cost share (**copayment**), as payment in full. **You** may receive a bill for the difference between the amount billed by the **provider** and the amount paid by this plan. If the **provider** bills **you** for an amount above **your** cost share, **you** are not responsible for paying that amount.
- **You** should send the bill to the address listed on the back of **your** ID card, and **we** will resolve any payment dispute with the **provider** over that amount. Make sure the member's ID number is on the bill.

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

| Description | In-Network |
|---|---|
| Clinical trial therapies (including routine patient costs) | 50% percentage copayment after **deductible** |

**Durable Medical Equipment (DME)**

| Description | In-Network |
|---|---|
| **DME** | 50% percentage copayment, no **deductible** applies |
| Limit per year | None |

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

| Description | In-Network |
|---|---|
| Hearing aids | 50% percentage copayment, no **deductible** applies |
| Hearing aids limit | Once every 3 years |
| Cochlear implants and related services | 50% percentage copayment, no **deductible** applies |
| Replacement of cochlear implant external speech processor and controller components limit | Once every 3 years |

**Nutritional Support**

| Description | In-Network |
|---|---|
| Nutritional support | 50% percentage copayment after **deductible** |

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

**Biomarker Testing**

| Description | In-Network |
|---|---|
| Biomarker Testing | 50% percentage copayment, no **deductible** applies |

**Orthotic Devices**

| Description | In-Network |
|---|---|
| Orthotic devices | 50% percentage copayment after **deductible** |

**Osteoporosis**

| Description | In-Network Coverage |
|---|---|
| Osteoporosis | 50% percentage copayment after **deductible** |

**Prosthetic Devices**

| Description | In-Network |
|---|---|
| Prosthetic devices | 50% percentage copayment, no **deductible** applies |

**Autism Spectrum Disorder**

| Description | In-Network |
|---|---|
| Autism spectrum disorder | $10 **copay**, no **deductible** applies |
| Applied behavior analysis | $10 **copay**, no **deductible** applies |

**Diabetic Equipment, Supplies And Education**

| Description | In-Network |
|---|---|
| Diabetic equipment, supplies, and education | 50% percentage copayment, no **deductible** applies |

**Jaw Joint Disorder Treatment**

| Description | In-Network |
|---|---|
| **Jaw joint disorder** treatment | 50% percentage copayment, no **deductible** applies |

**Behavioral Health**

**Mental Health Treatment**

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

| Description | In-Network |
|---|---|
| Inpatient mental health treatment | 50% percentage copayment, no **deductible** applies |
| Other inpatient mental health treatment services and supplies | 50% percentage copayment, no **deductible** applies |
| Outpatient mental health treatment visits to a **physician** or **behavioral health provider** | $10 **copay**, no **deductible** applies |
| Outpatient mental health **telemedicine** or **telehealth** cognitive therapy consultations by a **physician** or **behavioral health provider** | $10 **copay**, no **deductible** applies |
| Outpatient mental health **telemedicine** or **telehealth** visit | $10 **copay**, no **deductible** applies |

| | |
|---|---|
| Other outpatient mental health treatment or skilled behavioral health services in the home, **partial hospitalization treatment** and **intensive outpatient program** | $10 **copay**, no **deductible** applies |

**Substance Related Disorders Treatment**

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

| Description | In-Network |
|---|---|
| Inpatient **substance related disorders detoxification,** rehabilitation, and treatment in a **residential treatment facility** | 50% percentage copayment, no **deductible** applies |
| Other inpatient **substance related disorders detoxification** services and supplies, rehabilitation services and supplies, **residential treatment facility** services and supplies | 50% percentage copayment, no **deductible** applies |
| Outpatient **substance abuse** treatment visits to a **physician** or **behavioral health provider** | $10 **copay**, no **deductible** applies |
| Outpatient **substance abuse telemedicine** or **telehealth** cognitive therapy consultations by a **physician** or **behavioral health provider** | $10 **copay**, no **deductible** applies |
| Outpatient **substance related disorders telemedicine** or **telehealth** visit | $10 **copay**, no **deductible** applies |
| Other outpatient **substance related disorders** services or **partial hospitalization treatment** and **intensive outpatient program** | $10 **copay**, no **deductible** applies |

**Reconstructive Surgery And Supplies**

| Description | In-Network |
|---|---|
| Reconstructive breast **surgery** | 50% percentage copayment, no **deductible** applies |
| Other reconstructive **surgery** and supplies | 50% percentage copayment, no **deductible** applies |

**Transplant Services**

| Description | In-Network |
|---|---|
| Services and supplies | 50% percentage copayment, no **deductible** applies |

**Treatment Of Infertility**

| Description | In-Network |
|---|---|
| Basic **infertility** services | 50% percentage copayment after **deductible** |

## 11. Prescription Drugs/Medications

**Per Prescription Cost Share**

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

| Description | In-Network |
|---|---|
| For each 30 day supply filled at a **retail pharmacy** | $0 per **prescription** or refill, no **deductible** applies |
| Limit | Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, see the *How To Contact **Us** For Help* section. |

**Tier 2 - Generic Prescription Drugs**

| Description | In-Network |
|---|---|
| For each 30 day supply filled at a **retail pharmacy** | $10 **copay**, no **deductible** applies |
| For all fills greater than a 30 day supply but no more than a 90 day supply filled at a **retail pharmacy** or **mail order pharmacy** | $30 **copay**, no **deductible** applies |

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

| Description | In-Network |
|---|---|
| For each 30 day supply filled at a **retail pharmacy** | 20% percentage copayment, no **deductible** applies |
| For all fills greater than a 30 day supply but no more than a 90 day supply filled at a **retail pharmacy** or **mail order pharmacy** | |

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

| Description | In-Network |
|---|---|
| For each 30 day supply filled at a **retail pharmacy** | 50% percentage copayment, no **deductible** applies |
| For all fills greater than a 30 day supply but no more than a 90 day supply filled at a **retail pharmacy** or **mail order pharmacy** | |

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

**Tier 5 - Specialty Prescription Drugs**

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

| | |
|---|---|
| For each 30 day supply filled at a **specialty network pharmacy** | 50% percentage copayment, no **deductible** applies |

**Diabetic Supplies And Insulin**

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

**IMPORTANT NOTE:**
**Your** cost share will not exceed $25 per 30 day supply of a covered **prescription** insulin drug filled at a **network pharmacy**.

**IMPORTANT NOTE:**
When an emergency refill of diabetes supplies is provided, the emergency refill of insulin may not exceed a 30-day supply. The quantity of an emergency refill of insulin-related equipment or supplies may not exceed the lesser of a 30 day supply or the smallest available package.

**Nutritional Supports**

| Description | In-Network Coverage |
|---|---|
| Nutritional supports | Paid according to the tier of drug in the Schedule of Benefits, above |

**Orally Administered Anti-Cancer Medications**

| Description | In-Network |
|---|---|
| For each 30 day supply filled at a **retail pharmacy** or **specialty network pharmacy** | $0 per **prescription** or refill |

**Outpatient Contraceptive Prescription Drugs And Devices**

| Description | In-Network |
|---|---|
| Female contraceptives that are **generic prescription drugs** and OTC drugs and devices. For each 30 day supply | $0 per **prescription** or refill |
| Female contraceptives that are **brand-name prescription drugs** and devices. For each 30 day supply | Paid according to the tier of drug in the Schedule of Benefits, above |

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

**Risk Reducing Breast Cancer Prescription Drugs**

| Description | In-Network |
|---|---|
| For each 30 day supply filled at a **retail pharmacy** | $0 per **prescription** or refill |
| Limit | Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered risk reducing breast cancer **prescription drugs**, see the *How To Contact **Us** For Help* section. |

**Tobacco Cessation Prescription And Over-The-Counter Drugs**

| Description | In-Network |
|---|---|
| For each 30 day supply filled at a **retail pharmacy** | $0 per **prescription** or refill |
| Limit | • Coverage is limited to two, 90-day treatment programs only. Any additional treatment programs will be paid according to the tier of drug per the Schedule of Benefits, above.<br>• Coverage only includes a **generic prescription drug** when there is also a brand-name drug available.<br>• Coverage is subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered tobacco cessation **prescription drugs** and OTC drugs, see the *How To Contact **Us** For Help* section. |

**IMPORTANT NOTE:**

- See the *Outpatient Prescription Drugs, Other Services* section for more information on other prescription drug coverage under this plan.
- If **you** or **your prescriber** requests a covered **brand-name prescription drug** when a covered **generic prescription drug** equivalent is available, **you** will be responsible for the cost difference between the **generic prescription drug** and the **brand-name prescription drug**, plus the cost share that applies to **generic prescription drugs**.