IMPERIAL HEALTH PLAN
OF THE SOUTHWEST

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INDIVIDUAL AND FAMILY EXPLANATION OF COVERAGE (EOC) POLICY

This **Policy** is by and between Imperial Health Plan of the Southwest, Inc. (IHPSW, 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 Health Plan of the Southwest, a Utah domiciled health maintenance organization** admitted as a health care services organization in Utah and is governed by federal law and the laws of Utah.

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.

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.

WELCOME

This is **your Policy**. This and your Schedule of Benefits 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 Utah. 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 Health Plan of the Southwest**.

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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 Health Plan of the Southwest, 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 Salt Lake, Utah, and Washington 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:

- 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 partnership, 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.

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 30 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

If any renewal **premium** is not paid within the time granted to **you** for payment, a subsequent acceptance of premium by **us** or by any agent duly authorized by **us** to accept the premium, without also requiring an application for reinstatement, shall reinstate the **Policy**. However, if **we** require an application for reinstatement and issue a conditional receipt for the **premium** tendered, the **Policy** shall be reinstated upon approval of this application from us or, lacking this approval, upon the 45th day following the date of the conditional receipt, unless **we** have previously notified **you** in writing of its disapproval of the application. The reinstated **Policy** shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after that date. In all other respects, **you** and the Company have the same rights under the reinstated **Policy** as had under the **Policy** immediately before the due date of the defaulted **premium**, subject to any provisions endorsed on or attached to this **Policy** in connection with the reinstatement. Any **premium** accepted in connection with a reinstatement shall be applied to a period for which **premium** has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

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, a written renewal notice containing the change in **premium** will be sent to **you** at least 45 days before the day of the **Policy** renewal.

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 Utah
- 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** brother or sister who resides with **you**
- **Your** niece or nephew who resides with **you**
- **Your** collateral dependent who resides with **you**
- **Your** other relative who resides with **you**
- **Your** family member who **you** have an other relationship with and resides with **you**
- **Your** dependent children – **your** own or those of **your** spouse, domestic partner, or civil union partner

  The children must be 26 years of age or under, unless a **Dependent with a Disability**, 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
  - 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, from the moment of birth or the date of placement.

We may require **you** to provide proof of the requirements of a **Dependent with a Disability** within 30 days of the **Policy** effective date of coverage or the date the child reaches the age of 26 and annually after the two-year period following the child's 26th birthday.

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
  - In the event that there is a denial of a claim for services for **your** newborn child, **you** must enroll **your** child no later than 30 days after the first notification of denial of a claim.
- An adopted child – **You** may put an adopted child on **your Policy** from the moment of birth or the date of placement. "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
  - Coverage for **your** adopted child begins from the moment of birth if placement for adoption occurs within 30 days of the child's birth and 30 days from the date of placement if

placement occurs 30 days or more after the child's birth.
  - In the event that there is a denial of a claim for services for **your** adopted child, **you** must enroll **your** child no later than 30 days after the first notification of denial of a claim
- 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, or domestic partner, on **your Policy**:
  - **You** must complete **your** enrollment information and send it to **us** within 60 days after the date of **your** marriage, civil union, or 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
- Other relatives –**You** may put **your** grandchild, brother, sister, niece, nephew, other relative, or family member who **you** have an other relationship on **your Policy** if they reside with **you:**
  - The Marketplace or the Plan must receive **your** completed enrollment information within 60 days after the date the family member begins residing with **you**
  - Coverage will be effective on the first day of the month following plan selection

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,
- Ancillary Care provided at an In-Network facility in all circumstances, 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**.

Our clinical policy bulletins explain **our** policy for specific services and supplies. **We** use these bulletins and other resources to help guide individualized coverage decisions under **our** plans. **You** can find the bulletins and other information at www.Imperialhealthplan.com

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**

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
  - 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 Utah law including the cost of a newborn screening test kit in the amount provided by the Department of State Health 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 Utah 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** during an office visit.

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
- All prescription and over-the-counter contraceptive medications and devices for male Plan members.

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.

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.
- **You** will not incur any cost-sharing requirement for **out-of-network** that exceeds the **cost-sharing** requirement imposed for **in-network** for ground ambulance services.

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

Maternity, Related Newborn Care, And Adoption
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 Utah 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.

Adoption Indemnity Benefit
We provide an adoption indemnity benefit as required by Utah Code Annotated 31-A-22-610.1. In order to received this benefit, the child must be placed with **you** for adoption within 90 days of the child's birth. If you adopt more than one child from the same birth, only one adoption indemnity benefit applies. If each adoptive parent has coverage under separate health benefit plans, **we** will pay the pro rata share. The amount of the adoption indemnity benefit is $4,000.

This benefit is subject to **coinsurance**, **copays**, and **deductibles** applicable to the maternity benefits as outline in your coverage.

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
  - Prescription lenses include single vision, lined bifocal, lined trifocal, and lenticular lenses, including scratch-resistance, anti-reflective, and UV coating.
  - Eyeglass frames from the Otis & Piper collection are covered in full.

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 covered 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).

- 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.

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.

For a comprehensive list of Limitations and Exclusions, please see your **Schedule of Benefits.**

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 and younger than 76 years of age, or (2) a female older than 55 years of age and younger than 76 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.
- Cognitive rehabilitation associated with physical rehabilitation, but only when:
  - **Your** cognitive deficits are caused by neurologic impairment due to trauma, stroke, or encephalopathy.
  - The therapy is coordinated with **us** as part of a treatment plan intended to restore previous cognitive function.

Habilitation therapy services

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

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

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

Nutritional Support

Eligible health services include formula and low protein modified food products ordered by a **physician** for the treatment of phenylketonuria or an inherited disease or inborn errors of amino acids or urea cycle metabolism.

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 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.

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

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

Diabetic Equipment, Supplies And Education

Eligible health services include:

- Services

  - Foot care to minimize the risk of infection
- Supplies, as required in the Utah Code Annotated 31A-22-626:
  - 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.

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.
        - 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.

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**

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. **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 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 certain drugs

and devices that the FDA has approved to prevent pregnancy when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing. **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 methods identified by the FDA is included. **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.

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:

- Call **us** or contact **us** through **our** website at www.ImperialHealthPlan.com. For details, see the *Contact **Us** For Help* section in **your EOC**.

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

Chiropractic

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.

Dental Care Services And Anesthesia In A Hospital Or Surgery Center

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 complications 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

Hearing Aids And Cochlear Implants And Related Services

Jaw Joint Disorder Treatment

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**us**e by another patient

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

Personal Care, Comfort Or Convenience Items

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

Private Duty Nursing, Except As Described In The *Coverages - Hospital Care* section

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**
- Telephone calls
- 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 Of Infertility

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
- Ancillary Care – provided at an In-Network facility in all circumstances

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 Health Plan of the Southwest 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 90 days, but this may vary based on **your** condition.	Care will continue during a transitional period, usually 90 days, but this may vary based on **your** condition. 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 Health Plan of the Southwest
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 90 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 Health Plan of the Southwest
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 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 Health Plan of the Southwest

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 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**.

SECTION 8 – WHAT 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, when a **deductible** applies
- 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**.

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

When a **complaint** comes in, **we** review it, make a decision and tell **you** of our decision. **We** also explain what **you** can do if **you** think the decision was incorrect. For a detailed explanation of the appeal process in connection with any **complaint**, please review the following information:

Members that have a problem with any Imperial Health Plan of the Southwest services can contact **our** Member Services Department or send the problem or **complaint** in writing by mail or filing online.

Complaint and Appeals Contact Information:

Imperial Appeals and Grievances

1100 East Green Street,

Pasadena, CA 91106

Website: https://exchange.imperialhealthplan.com/utah

Toll-Free Phone: 1 (866)777-1405. TTY users may dial (800) 708-5976, 711 or

The Utah Insurance Department Consumer Services at: 4315 S 2700 W Ste 2300

Taylorsville, UT 84129

801-957-9280

E-mail: healthappeals.uid@utah.gov

Definitions

Capitalized and bold terms in the Complaints, Grievances and Appeals section only apply to this section and have the following definitions:

Authorized Representative: An individual authorized in writing by a Member or Utah Law to act on their behalf in requesting a healthcare service, obtaining claim payment, or during the **internal appeal** process. A health care provider may act on behalf of a Member without their express consent when it involves an **Urgent Care Service**.

Adverse Benefit Determination: The denial, reduction, or termination of a benefit; failure to provider or make payment, in whole or in part, for a benefit; or the rescission of coverage based on requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of an **eligible health service**. A Final Adverse Benefit Determination is an **Adverse Benefit Determination** that is upheld after the **internal appeal** process. If the period allowed for the **internal appeal** elapses without a determination by **us**, then the **internal appeal** is a **Final Adverse Benefit Determination**.

Independent Review Organization (IRO): An organization renders an independent and impartial decision on a **Final Adverse Benefit Determination**.

Post-Service Claim: **We** rendered an **Adverse Benefit Determination** for a service that completed.

Pre-Service Claim: We rendered an **Adverse Benefit Determination**, and the requested service was not completed.

UID: The Utah Insurance Department and Office of the Commissioner.

Urgent Care Services Claim: **We** rendered an **Adverse Benefit Determination**, and the requested service did not complete, where the application of non-Urgent Care appeal periods could seriously jeopardize: a Member's life or health or that of their unborn child; or in the opinion of the treating Provider, would subject a Member to severe pain unless a Member receives the care or treatment that is the subject of the **Internal Appeal**.

Complaint: A Complaint is any dissatisfaction that a Member has with Imperial Health Plan of the Southwest or any Participating Provider that is not related to the denial of healthcare services. For example, a Member may be dissatisfied with the hours of availability of a Member's doctor. Issues relating to the denial of healthcare services are Appeals and should be filed by mail, phone or online with **us** or the Utah Insurance Department (UID).

We will respond to a Member **complaint** no later than 60 days from receipt of the **Complaint**.

Internal Appeal: A Member, Member's **Authorized Representative**, or a treating Provider or facility may submit an appeal of an **Adverse Benefit Determination**. **We** will provide the Member with the forms necessary to initiate an appeal. A Member may request these forms by contacting **our** Appeals and Grievance Department. While Member's are not required to use **our** forms, **we** strongly encourages that an appeal be submitted on such form to facilitate logging, identification, processing, and tracking of the appeal through the review process. If a Member needs assistance in preparing the appeal, or in submitting an appeal verbally, a Member may contact **us** for such assistance. A Member or their **Authorized Representatives** must file an appeal within 180 days from the date of the notice of **Adverse Benefit Determination**. Within 5 business days of receiving an appeal, **we** will send a Member or their **Authorized Representative** a letter acknowledging receipt of the appeal. Member's coverage will remain in effect pending the outcome of their **internal appeal**. The appeal will be reviewed by personnel who were not involved in the making of the **Adverse Benefit Determination** and will include input from healthcare professionals in the same or similar specialty as typically manages the type of medical service under review.

Timeframe: **We** shall respond to the following types of appeal requests in the following time frames:

- **Urgent Care Services**: Within 72 hours
- **Pre-Service Claim**: Within 30 days
- Concurrent service (a request to extend or a decision to reduce a previously approved course of treatment): Within 72 hours for in-network
- **Post-Service Claim**: Within 60 days

Exhaustion of Process: The preceding procedures and processes are mandatory and must be exhausted prior to establishing litigation or any administrative proceeding regarding matters within the scope of this

section.

General Rules and Information

A Member must cooperate fully with **us** to promptly review and resolve a **complaint** or appeal. In the event a Member does not fully cooperate with **us**, it will be deemed that the Member has waived their right to have the **Complaint** or Appeal processed within the periods set forth above. will offer to meet with a Member by telephone or in person. **We** will make appropriate arrangements to allow telephone conferencing or an in-person meeting upon request at **our** administrative offices or via electronic video conferencing (e.g., Teams, Zoom etc . . .) **We** will make these arrangements with no additional charge to a Member. During the review process, **we** will review the services in question without regard to the decision reached in the initial determination. **We** will provide the Member with new or additional informational evidence that it considers, relies upon, or generates in connection with an appeal that was not available when **we** made the initial **Adverse Benefit Determination**. A "full and fair" review process requires **us** to send any new medical information to review directly so a Member have an opportunity to review the claim file.

Independent Review Process

A Member may request an independent review of an **Adverse Benefit Determination** only after exhausting **our** internal review process described above unless: (1) **We** agree to waive the internal review process; (2) **We** have not complied with the requirements of the internal review process, except where those failures are nominal violations that do not cause, and are not likely to cause, prejudice or harm to the Member and are not part of a pattern or practice failing to follow the requirements; or (3) a Member has requested an expedited independent review at the same time.

We will pay the cost for an **IRO** to conduct a review of an **Adverse Benefit Determination**. A Member may request an independent review regardless of the dollar amount of the claim or services involved. A Member must file a request with **UID** for an independent review no later than 180 days after a Member receives the **Final Adverse Benefit Determination** notice from **us**. If a Member sends the request to **us**, **we** will forward the request to the **UID** within 1 business day of receipt. A Member must use the Independent Review Request Form available at www.insurance.utah.gov or from **our** Appeals and Grievance Department to file the request. The independent review request must contain an authorization for the necessary parties to obtain medical records for purposes of deciding on the independent review request.

The independent review decision is binding on Imperial Health Plan of the Southwest and the Member except to the extent that other remedies are available under federal and Utah Laws.

Upon receipt of the Independent Review Request Form, **UID** will send a copy of the request to **us**. Within 5 business days following receipt of the request, **we** will determine whether

a. the individual was a Member at the time of rescission or the healthcare service was requested or

provided;

b. a healthcare service that is the subject of an **Adverse Benefit Determination** is a Covered Service;

c. the Member has exhausted **our** internal review process described above; and

d. the Member has provided all the information and forms required for the independent review. Within 1 business day of making these determinations, **we** will notify **UID** and the Member in writing whether the request is complete and eligible for independent review. If the request is not complete, **we** will inform the Member and **UID** in writing what information or materials are needed to make the request complete. If the request is not eligible for independent review, **we** will inform the Member and **UID** in writing of the reasons why the request is not eligible for independent review and inform the Member that the determination may be appealed to **UID**. **UID** may decide in accordance with the terms of this Agreement that the request is eligible for independent review despite **our** determination that the request is not eligible in which case the request will be independently reviewed. If a request is eligible for independent review, **UID** will:

- Assign on a random basis an **IRO** from the list of approved **IROs** based on the nature of the healthcare service that is subject to review;
- Notify **us** of the assignment and require **us** to provide to the **IRO** the documents and any information considered in making the **Adverse Benefit Determination** within 5 business days; and
- Notify the Member that the request has been accepted and the Member may submit additional information to the **IRO** within 5 business days of receipt of the **UID's** notice.

The **IRO** will forward to **us** within 1 business day of receipt any information submitted by the Member. The **IRO** will provide notice of its decision to uphold or reverse the **Adverse Benefit Determination** within 45 calendar days to the Member, **us** and **UID**. If the **Adverse Benefit Determination** is reversed, **we** will approve the coverage that was the subject of the **Adverse Benefit Determination** and process any benefit that is due within 1 business day of the notice.

Expedited Independent Review Requests

An expedited independent review is available when the **Adverse Benefit Determination**:

- Involves a medical condition which would seriously jeopardize the life and health of the Member or jeopardize the Member's ability to regain maximum function;
- In the opinion of the Member's attending provider, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the **Adverse Benefit Determination**; or
- Concerns an admission, availability of care, continued stay or health care service for which the Member received Emergency Services, but has not been discharged from a facility.

Upon receipt of the Independent Review Request Form, **UID** will immediately send a copy of the request to **us**. Immediately upon receipt, **we** will determine whether:

a. the individual was a Member at the time the healthcare service was requested or provided;
b. a health care service that is the subject of an **Adverse Benefit Determination** is a Covered Service; and
c. the Member has provided all the information and forms required for the expedited independent review. **We** will immediately notify the **UID** and the Member whether the request is complete and eligible for expedited independent review.

If the request is not complete, **we** will inform the Member and the **UID** in writing what information or materials are needed to make the request complete. If the request is not eligible for expedited independent review, **we** will inform the Member and **UID** in writing of the reasons why the request is not eligible for expedited independent review and inform the Member that the determination may be appealed to **UID**. **UID** may decide in accordance with the terms of this Agreement that the request is eligible for expedited independent review despite **our** determination that the request is not eligible in which case the request will be independently reviewed If a request is eligible for expedited independent review, the **UID** will:

- Assign on a random basis an **IRO** from the list of approved **IRO** based on the nature of the health care service that is subject to review;
- Notify **us** of the assignment and require **us** within five days to provide to the **IRO** the documents and any information considered in making the **Adverse Benefit Determination**; and
- Notify the Member that the request has been accepted and the Member may submit additional information to the **IRO** within five days of receipt of the **UID's** notice.

The **IRO** will forward to **us** within 1 business day of receipt any information submitted by the Member. The **IRO** will as soon as possible, but not later than 72 hours after receipt of the request for an expedited independent review, provide notice of its decision to uphold or reverse the **Adverse Benefit Determination** to the Member, **us** and **UID**. If the notice is not in writing, the **IRO** must provide written confirmation of its decision within 48 hours after the date of notification of the decisions. If the **Adverse Benefit Determination** is reversed, **we** will approve the coverage that was the subject of the **Adverse Benefit Determination** and process any benefit that is due within 1 business day of the notice.

Independent Review Requests Based on Experimental or Investigational Services

If a Member submits a request for independent review involving Experimental or Investigational Services, the request must contain a certification from the Member's Provider that (a) standard health care service or treatment has not been effective in improving the Member's condition; (b) standard healthcare services or treatments are not medically appropriate for the Member; or (c) there is no available standard healthcare service or treatment covered by the Plan that is more beneficial than the recommended or requested health care service or treatment. Upon receipt of the Independent Review Request Form involving

experimental or investigation services or treatments, the **UID** will send a copy of the request to **us**. Within 5 business days, or 1 business day for expedited requests, following receipt of the request, **we** will determine whether (a) the individual was a Member at the time the health care service was requested or provided; (b) the health care service that is the subject of an **Adverse Benefit Determination** is a Covered Service, except that the service or treatment is experimental or investigational for a particular medical condition and is not explicitly listed as an excluded benefit in the EOC; (c) the Member has exhausted **our** internal review process described above, unless the request is for an expedited review; and (d) the Member has provided all the information and forms required for the independent review. Within one business day of making these determinations, **we** will notify the **UID** and the Member in writing whether the request is complete and eligible for independent review. If the request is not complete, **we** will inform the Member and the **UID** in writing what information or materials are needed to make the request complete.

If the request is not eligible for independent review, **we** will inform the Member and the **UID** in writing of the reasons why the request is not eligible for independent review and inform the Member that the determination may be appealed to the Utah Insurance Commissioner. The **UID** may decide in accordance with the terms of this EOC that the request is eligible for independent review despite **our** determination that the request is not eligible in which case the **UID** will independently review the **complaint**. If a request is eligible for independent review, the **UID** will:

- Assign on a random basis an **IRO** from the list of approved **IRO** based on the nature of the health care service that is subject to review;
- Notify **us** of the assignment and require **us** within five business days, or one business day for a request for expedited review, to provide to the **IRO** the documents and any information considered in making the **Adverse Benefit Determination**; and
- Notify the Member that the request has been accepted and the Member may submit additional information to the IRO within 5 business days, or one business day for expedited review requests, of receipt of the Utah Insurance Commissioner's notice. The IRO will forward to **us** within 1 business day of receipt any information submitted by the Member. Within one business day of receipt of the request, the IRO will select a one or more clinical reviews to conduct the review. The clinical reviewer will provide the IRO a written opinion with 20 calendar days, or 5 calendar days for an expedited review, after being selected. The IRO will decide based on the clinical reviewer's opinion within 20 calendar days of receipt of the opinion, or 48 hours in the case of an expedited review, and provide notice of its decision the Member, **us** and the Utah Insurance Commissioner. If the Adverse Benefit Determination is reversed, **we** will approve the coverage that was the subject of the Adverse Benefit Determination and process any benefit that is due within one business day.

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** will send **you** a written notification of discontinuation at least ninety (90) calendar days before the date the coverage will be discontinued.
- **We** withdraw from the individual market in the state, if approved by the insurance department of the state where this **Policy** was issued. **We** will send **you** a written notification of discontinuation at least 180 calendar days to all affected.
- **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 15 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.

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**.

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 Utah 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 Health Plan of the Southwest 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 Health Plan of the Southwest 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 Health Plan of the Southwest 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.

Recovery of Overpayments will comply with the following timeframe:

- Within 24 months of the amount improperly paid for a coordination of benefits error,
- Within 36 months of the amount improperly paid when the improper payment was due to a recovery by Medicaid, Medicare, the Children's Health Insurance Program, or any other state or federal health care program,
- Within 12 months of the amount improperly paid for reasons not listed above.

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.

SECTION 12 – DEFINITIONS

Imperial, IHPSW
Imperial Health Plan of the Southwest, Inc., is the HMO contracted to pay for your covered benefits.

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.

Coinsurance
The percentage of the charge of a covered health care service (20%, for example) you pay after you've paid your **deductible** (unless stated otherwise).

Copay, Copayment
A fixed amount **you** pay for a covered health care service after you've paid your **deductible** (unless stated otherwise).

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**, person, or facility, licensed or certified by **applicable law** to provide **you** with dental care services.

Dependent with a Disability

A child who is and continues to be both: (1) unable to engage in substantial gainful employment to the degree that the child can achieve economic independence due to a medically determinable physical or mental impairment which can be expected to result in death, or which has lasted or can be expected to last for a continuous period of not less than 12 months; (2) chiefly dependent upon an insured for support and maintenance since the child reached the age of 26; and (3) have been continuously enrolled in some form of healthcare coverage, with no break in coverage of more than 63 days since the date they reached age 26.

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 Health Plan of the Southwest 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

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 or products that a prudent health care professional would provide to a patient for the purpose of preventing, diagnosing or treating an **illness**, **injury**, disease or its symptoms in a manner that is:

(i) in accordance with generally accepted standards of medical practice in the United States;
(ii) clinically appropriate in terms of type, frequency, extent, site, and duration;
(iii) not primarily for the convenience of the patient, physician, or other health care provider; and
(iv) covered under the contract.

When a medical question-of-fact exists medical necessity shall include the most appropriate available supply or level of service for the individual in question, considering potential benefits and harms to the individual, and known to be effective.

(i) For interventions not yet in widespread use, the effectiveness shall be based on scientific evidence.
(ii) For established interventions, the effectiveness shall be based on:
    (A) scientific evidence;
    (B) professional standards; and
    (C) expert opinion.

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** may not be

defined more restrictively than a definition including neurosis, psychoneurosis, psychosis, or any other mental or emotional disease or disorder which does not have a demonstrable organic cause.

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
An order issued:

- by a licensed practitioner in the course of that practitioner's professional practice or by collaborative **pharmacy** practice agreement; and
- for a controlled substance or other **prescription drug** or device for use by a patient

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 Utah 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 Utah, or a **health professional** acting under the delegation and supervision of a **physician** licensed in the State of Utah 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**