IMPERIAL INSURANCE COMPANIES

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Arizona Small Group
Health Maintenance Organization (HMO)
CERTIFICATE OF COVERAGE

WELCOME

This is **your** Certificate of Coverage, or "certificate". It is one of the documents that together describe the benefits **you** have and the terms of this plan**.**

This certificate 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** plan covers only a certain number of visits. Together with the Group Agreement, these documents describe your plan and coverage.

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

It is important that **you** read **your** plan documents carefully, and in their entirety. If **you** need help or more information, see the *How to Contact Us For Help* section on page 5.

Where to next? Try *Section 1 - Introduction to **Your** Plan* beginning on page 3. It gives **you** a summary of how **your** plan works. The more **you** understand, the more **you** can get out of **your** coverage.

Welcome to **Imperial**.

IMPERIAL INSURANCE COMPANIES

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IMPERIAL INSURANCE COMPANIES

SECTION 1 – INTRODUCTION TO YOUR PLAN

Here are some basics. Please see below on how **we** use defined terms. Then **we** explain how **your** plan 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 certificate 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** and any covered dependents if dependent coverage is available under the plan.
- When **we** say "**us**", "**we**", and "**our**", **we** mean Imperial Insurance Companies, Inc.
- Some words appear in **bold** type. **We** define them in *Section 11 – Definitions*, page 79.

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

What Is Your Plan? – Provides Covered Benefits

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

How Does Your Plan Work? – Starts And Stops Coverage

Coverage under the plan has a start and an end. First, **you** complete the eligibility and enrollment process. Then **your** coverage starts on the **effective date of coverage** or later if **you** are a dependent that was added to coverage. Coverage is not provided for any services received before coverage starts or after coverage ends.

Dependent coverage starts on the **effective date of coverage** if the employee enrolled them at that time. See *Section 2 – Who the group plan covers*, beginning on page 6 for details.

Your coverage typically ends when **you** leave your job; but it can happen for other reasons. Ending coverage under the plan does not necessarily mean **you** lose coverage with **us**. There will be circumstances that will allow you to continue coverage. To learn more, see *Section 9 – When Coverage Ends*, beginning on page 71.

How Does Your Plan 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 plan 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 *Section 4 – Coverages*, beginning on page 12.

- They are not listed in *Section 5 -General Exclusion*, beginning on page 58.
- They fall within the benefit limits stated 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 at www.Imperialhealthplan.com. See the *How To Contact **Us** For Help* section on page 5.

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 *Section 6 – Who Provides The Care* beginning on page 63 in **your** certificate.

3. Service area

Your plan generally pays for **eligible health services** only within a specific geographic area, called a **service area**. The **service area** of this plan is Maricopa County. **You** must live or work in the service area. There are some exceptions, such as for **emergency services** and urgent care. See *Section 6 – Who Provides The Care* beginning on page 63 in **your** certificate.

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 plan 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**
- **You** or **your provider preauthorizes** the **eligible health service** when required

You will find details on **medical necessity**, **referral** and **preauthorization** requirements in *Section 3 – Medical Necessity, Referral And Preauthorization Requirements* beginning on page 9. **You** will find the requirement to use a **network provider**, any exceptions, and other information in *Section 6 – Who Provides The Care* beginning on page 62.

5. Paying for eligible health services – sharing the expense

Generally, **your** plan and **you** will share the expense of **your eligible health services** when **you** meet the general requirements for paying.

But sometimes **your** plan will pay the entire expense; and sometimes **you** will. For more information see the Schedule of Benefits and *Section 7 – What **We** Pay And What **You** Pay* beginning on page 66 in **your** certificate.

6. Premiums and Your Contributions

The **contract holder** is responsible for paying the **premium** due under the Group Agreement. **You** may be required to make a **contribution** toward the cost of **your** coverage and any dependent coverage. The amount of any required **contribution** is determined by the **contract holder**.

Your coverage may end if **you** fail to make a required **contribution** toward the cost of **your** coverage. See *Section 9 – When Coverage Ends*, beginning on page 71 for more information.

How to 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
- Visiting the website at www.Imperialhealthplan.com
- 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 plan. 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 at www.Imperialhealthplan.com. See the *How To Contact **Us** For Help* section on page 5. **You** can print **your** ID card or request a paper copy from us by U.S. mail.

Inform Us Of Any Changes

If there are any changes which will affect **your** plan or the eligibility of anyone covered under the plan, **you** must contact **us** 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 program like Medicare, Medicaid or the Children's Health Insurance Program (CHIP)

It is important that **you** inform **us** 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* section on page 7 in **your** certificate for information on special or limited enrollment periods.

IMPERIAL INSURANCE COMPANIES

SECTION 2 – WHO THE GROUP PLAN COVERS

You will find information in this section about:

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

Who Is Eligible

Your employer decides and tells us who is eligible for health care coverage.

When you can join the plan

You can enroll if **you** live or work in the **service area:**

- At the end of any waiting period the **contract** holder requires
- Once each year during the annual enrollment period
- At other special times during the year (see the *Special or Limited Enrollment Periods* section below)

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

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

- **Your** legal spouse
- **Your** civil union partner who meets eligibility requirements under **applicable law**
- **Your** domestic partner who meets eligibility requirements under **applicable law**.
- **Your** dependent children – **your** own or those of **your** spouse, domestic partner or civil union partner
    - The children must be under 26 years of age, unless reliant on the parent due to physical or mental impairment, and they include **your**:
        - Biological children
        - Stepchildren
        - Legally adopted children*, including children placed with **you** for adoption
        - Foster children
        - Children **you** are responsible for under a qualified medical or dental support order or court-order (whether or not the child resides with **you**)
        - Grandchildren in **your** court-ordered custody

***Your** adopted child may be enrolled as shown in the *Adding New Dependents* section on page 8 in **your** certificate at **your** option, after the date:

- **You** become a party in a suit for adoption, or
- The adoption becomes final

Effective date of coverage

Your coverage will start after **we** have received **your** completed enrollment information. Depending on when **you** enroll, the start date will be either:

- On the date the **contract holder** tells **us**
- As described under the *Special or Limited Enrollment Periods* section below

Dependent coverage will start:

- On **your** effective date, if **you** enrolled them at that time.
- Generally, the first day of the month based on when **we** receive **your** completed enrollment information if **you** enrolled them at another time. See *Adding new dependents* and *Special or Limited Enrollment Periods* below for more information.

Special Or Limited Enrollment Periods

Each new employee of the **group** who becomes eligible for coverage at a time other than the initial enrollment or **Group** Open Enrollment Period may enroll himself and eligible Dependents. If application is not made timely, the newly eligible employee may not be added until the next **Group** Open Enrollment Period. The Effective Date of Coverage is the first day of the month following the date employee becomes eligible, unless otherwise specified and agreed upon by the **group** and **us**.

You can enroll in these situations:

- **You** didn't enroll before because **you** had other coverage and that coverage has ended.
- **Your** COBRA coverage has ended.
- A court orders that **you** cover a dependent on **your** health plan.
- **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 qualify for access to new plans because **you** have moved to a new permanent location.

We must receive the completed enrollment form within 31 days after the event date.

You can also enroll in these situations:

- **You** or **your** dependent lose **your** eligibility for enrollment in Medicaid or an S-CHIP plan
- **You** are now eligible for state premium assistance under Medicaid or S-CHIP which will pay **your** premium contribution under this plan

We must receive the completed enrollment information within 60 days after the date Medicaid or S-CHIP coverage ends, or within 60 days after the date you or your dependent is determined eligible for premium assistance, as applicable.

Effective date of coverage

Your coverage will start based on when **we** receive **your** completed enrollment information:

- No later than the first day of the month following the date **we** receive **your** completed enrollment information
- In accordance with the effective date of a court order
- An appropriate date based on the circumstances of the special enrollment period

Notification of change in status

Tell **us** of any changes that might affect **your** benefits. Please contact **us** as soon as possible when **you** have a:

- Change of address or phone number
- Change in marital status

- Covered dependent status change
- Dependent who enrolls in Medicare or any other health plan

Adding New Dependents

You can add new dependents during the year. These include any dependents described in the *Who can be on your plan* section above on page 6.

Coverage begins on the date of the event for new dependents that join **your** plan for the following reasons:

- Birth
- Adoption or placement for adoption
- Marriage
- Legal guardianship
- Court or administrative order

We must receive completed enrollment information not more than 31 days after the event date.

SECTION 3 – MEDICAL NECESSITY, REFERRAL, AND PREAUTHORIZATION REQUIREMENTS

The starting point for **covered benefits** under **your** plan is whether the services and supplies are **eligible health services**. See *Section 4 – Coverages* beginning on page 11 and *Section 5 – General Exclusions* beginning on page 57 in **your** certificate plus the Schedule of Benefits.

Your plan 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 **referral** from **your PCP**
- **You** or **your provider preauthorizes** the **eligible health service** when required

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

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

This section addresses the **medical necessity**, **referral** and **preauthorization** requirements. **You** will find the requirement to use a **network provider** and any exceptions to this in *Section 6 - Who Provides The Care* beginning on page 63 in **your** certificate.

Medically Necessary; Medical Necessity

As stated in *Section 1 - Introduction to **Your** Plan* beginning on page 4, **medical necessity** is a requirement for **you** to receive **eligible health services** under this plan.

The **medical necessity** requirements are in Section 11 – Definitions beginning on page 79 in **your** certificate, 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 *Section 7 – What **We** Pay And What **You** Pay* in **your** certificate.

Preauthorization

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

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 *Prescription Drugs/Medications – What Preauthorization Requirements Apply* section on page 55. 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 certificate.

A prior authorization request, once granted or deemed granted, is binding on the health care services plan, may be relied on by the enrollee and provider and may not be rescinded or modified by a health care services plan or its utilization review agent after the provider renders the authorized health care services in good faith and pursuant to the authorization unless there is evidence of fraud or misrepresentation by the provider.

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

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

Please see the Health Care Insurer Appeals Process packet, which is provided along with this certificate, and *Section 8 – When **You** Have a Complaint or Appeal*, page 70 for more information on **your** appeals rights.

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SECTION 4 – COVERAGES

The information in this section is the first step to understanding **your** plan's **eligible health services**. If **you** have questions about this section, see the *How To Contact **Us** For Help* section on page 5 in **your** certificate.

Your plan 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 coverage exclusions in *Section 5 – General Exclusions* beginning on page 57 in **your** certificate 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** plan 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 (https://www.cdc.gov/vaccines/acip/)
   - United States Preventive Services Task Force (https://www.uspreventiveservicestaskforce.org/uspstf/)
   - Health Resources and Services Administration (https://www.hrsa.gov/)
   - American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents (https://www.aap.org/en/practice-management/bright-futures/)

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 on page 5 in **your** certificate. 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. More information can be found here: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations
- Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents. More information can be found here: https://www.aap.org/en/practice-management/bright-futures/bright-futures-materials-and-tools/bright-futures-guidelines-and-pocket-guide/
- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. More information can be found here: https://www.hrsa.gov/womens-guidelines. These services 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 Arizona law including the cost of a newborn screening test kit in the amount provided by the Department of State Health Services. More information can be found here: https://www.azdhs.gov/preparedness/state-laboratory/newborn-screening/index.php.

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 include:

- Diphtheria, tetanus, pertussis
- Hemophiles 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** plan 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** plan 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, once per plan year, or at other intervals following guidelines as recommended by the National Comprehensive Cancer Network (NCCN)
  - This includes digital breast tomosynthesis, magnetic resonance imaging, ultrasound or other modality as recommended by the NCCN
  - More information can be found here: https://www.nccn.org/guidelines/guidelines-detail?category=patients&id=66
- 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 Arizona 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), counseling services, education by clinicians, and peer support groups during pregnancy or at any time following delivery for breast feeding. **Your** plan 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**
  - Telephone calls are included when the use of an audio-only telephone encounter between an enrollee who has an existing relationship with a health care provider or provider group if both of the following apply:
    - An audio-visual telehealth encounter is not reasonably available due to the enrollee's functional status, the enrollee's lack of technology or telecommunications infrastructure limits, as determined by the health care provider.
    - The telehealth encounter is initiated at the request of the enrollee or authorized by the enrollee before the telehealth encounter.

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 *Section 4 – Coverages – Inpatient and Outpatient Hospital Services* section below.
- 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** plan 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.
- Intravenous (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.
- A prior authorization request, once granted or deemed granted, is binding on the health care services plan, may be relied on by the enrollee and provider and may not be rescinded or modified by a health care services plan or its utilization review agent after the provider renders the authorized health care services in good faith and pursuant to the authorization unless there is evidence of fraud or misrepresentation by the provider.

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 plan

Certain infused medications may be covered under the *Section 4 – Coverages – **Prescription Drugs/Medications*** section beginning on page 49.

See the *How To Contact **Us** For Help* section on page 5 in **your** certificate to:

- Access the list of **specialty prescription drugs**
- Determine if coverage for a **specialty prescription drug** is under the *Section 4 – Coverages – **Prescription Drugs/Medications*** section, beginning on page 49, 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** plan 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 *Section 4 – Coverages – Inpatient and Outpatient Hospital Services* section beginning on page 16 in **your** certificate.
- A separate facility charge for **surgery** performed in a **physician's** office.
- Service of another **physician** for the administration of a local anesthetic.

Dental Care Services And Anesthesia In A Hospital Or Surgery Center

Eligible health services include dental care and anesthesia in a **hospital** or **surgery center** only if **your provider** tells **us you**:

- Have a physical, mental, or medical condition that requires **you** be treated in a **hospital** or **surgery center**
- Are developmentally disabled

Are in poor health and have a medical need for general anesthesia

Home Health Care

Eligible health services include home health care services provided by a **home health agency** in the home,

but only when all of the following criteria are met:

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

If **you** are discharged from a **hospital** or **skilled nursing facility** after a **stay**, the intermittent requirement may be waived to allow coverage for continuous **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 Schedule of Benefits and the *Short-Term Rehabilitation Services* section on page 38 of **your** certificate.

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.
- Treatment to stabilize **your** emergency medical condition given in a hospital's emergency room (regardless of the department of the hospital), freestanding emergency facility, or comparable emergency facility.
- 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.
- Services or items for which benefits are provided or covered under the plan or coverage and that are furnished by a **nonparticipating provider** or **nonparticipating emergency facility** (regardless of the department of the hospital in which such items or services are furnished) after **your** condition is stabilized and as part of **outpatient observation** or an **inpatient or outpatient stay** with respect to the **emergency visit**.

IMPORTANT NOTE:

- **Out-of-network providers** do not have a contract with **us**. The **provider** may not accept payment of **your** cost share (**copayment**), as payment in full. **You** may receive a bill for the difference between the amount billed by the **provider** and the amount paid by this plan. If the provider bills **you** for an amount above **your** cost share, **you** are not responsible for paying that amount.
- **You** should send the bill to the address listed on the back of **your** ID card 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.
- In the following situations, **you** are not responsible for any amounts above the **in-network cost-sharing** amount for such service calculated in accordance with the Federal No Surprises Act of 2020, and any implementing rules:
    - While obtaining **emergency services** at certain non-network emergency facilities or from certain **out-of-network providers**, as set forth in the definitions and terms and conditions of the Federal No Surprises Act of 2020, and any implementing rules;
    - While obtaining certain **non-emergency services** performed by certain non-network providers at certain **network facilities** (including, but not limited to, a hospital, a hospital outpatient department, a critical access hospital, or an ambulatory surgical center), as set forth in the definitions and under the terms and conditions of the Federal No Surprises Act of 2020, and any implementing rules, unless you have consented in a manner consistent with the Federal No Surprises Act of 2020; or
    - While obtaining **air ambulance services** from certain **non-network providers**, as set forth in the definitions and under the terms and conditions of the Federal No Surprises Act of 2020, and any implementing rules.

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 *Section 3 - Medical Necessity, Referral And Preauthorization Requirements* beginning on page 9 in **your** certificate 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 Section 11 – Definitions beginning on page 79 for specific plan 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 *Section 5 – General Exclusions* beginning on page 57 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 And Related Newborn Care

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

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

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

- **Your** home
- A health care **provider's** office
- A health care facility
- Another location determined to be appropriate under applicable Arizona 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. Breast feeding equipment and supplies include, but are not limited to, double electric breast pumps (including pump parts and maintenance) and breast milk storage supplies. Breastfeeding equipment may also include equipment and supplies as clinically indicated to support dyads with breastfeeding difficulties and those who need additional services. These **eligible health services** are available during pregnancy or at any time following delivery for breast feeding.

Breast Pump
Eligible health services include one personal-use breast pump per pregnancy through:

- 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** plan will cover this cost once per pregnancy.
  - A manual breast pump. **Your** plan will cover this cost once per pregnancy.

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

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

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

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

8. Pediatric

Pediatric Vision Care

Routine vision exams

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

Vision Care Supplies

We provide vision eyewear coverage that can help pay for **prescription** eyeglasses or **prescription** contact lenses. **You** have access to an extensive network of vision locations. If **you** have questions, see the *How To Contact **Us** For Help* section on page 5.

Eligible Health Services include:

- Eyeglass frames, **prescription** lenses or **prescription** contact lenses
  - **Prescription** lens options include single vision, lined bifocal, lined trifocal, and lenticular lenses, including scratch-resistant, anti-reflective, and UV coating.

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 plan 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 plan 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.**

The following table contains all Current Dental Terminology (CDT) Codes covered under this benefit. Please see your Schedule of Benefits for additional information about the cost sharing and limits that apply.

D0120	Periodic oral evaluation - established patient
D0140	Limited oral evaluation - problem focused
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver
D0150	Comprehensive oral evaluation - new or established patient
D0160	Detailed and extensive oral evaluation - problem focused, by report
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)
D0171	Re-evaluation - post-operative office visit
D0180	Comprehensive periodontal evaluation - new or established patient
D0190	Screening of a patient
D0191	Assessment of a patient
D0210	Intraoral - comprehensive series of radiographic images
D0220	Intraoral - periapical first radiographic image
D0230	Intraoral - periapical each additional radiographic image
D0240	Intraoral - occlusal radiographic image
D0270	Bitewing - single radiographic image
D0272	Bitewings - two radiographic images
D0273	Bitewings - three radiographic images
D0274	Bitewings - four radiographic images
D0277	Vertical bitewings - 7 to 8 radiographic images
D0330	Panoramic radiographic image
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally
D0364	Cone beam CT capture and interpretation with limited field of view - less than one whole jaw
D0365	Cone beam CT capture and interpretation with field of view of one full dental arch - mandible
D0366	Cone beam CT capture and interpretation with field of view of one full dental arch - maxilla, with or without cranium
D0367	Cone beam CT capture and interpretation with field of view of both jaws; with or without cranium
D0391	Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report
D0419	Assessment of salivary flow by measurement
D0460	Pulp vitality tests
D0470	Diagnostic casts
D0601	Caries risk assessment and documentation, with a finding of low risk
D0602	Caries risk assessment and documentation, with a finding of moderate risk
D0603	Caries risk assessment and documentation, with a finding of high risk
D0701	Panoramic radiographic image - image capture only
D0702	2D cephalometric radiographic image - image capture only
D0703	2D oral/facial photographic image obtained intra-orally or extra-orally - image capture only
D0706	Intraoral - occlusal radiographic image - image capture only
D0707	Intraoral - periapical radiographic image - image capture only
D0708	Intraoral - bitewing radiographic image - image capture only
D0709	Intraoral - comprehensive series of radiographic images - image capture only
D0999	Unspecified diagnostic procedure, by report
D1110	Prophylaxis - adult
D1120	Prophylaxis - child

D1206	Topical application of fluoride varnish
D1208	Topical application of fluoride - excluding varnish
D1351	Sealant - per tooth
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth
D1353	Sealant repair - per tooth
D1354	Application of caries arresting medicament - per tooth
D1510	Space maintainer - fixed, unilateral - per quadrant
D1516	Space maintainer - fixed - bilateral, maxillary
D1517	Space maintainer - fixed - bilateral, mandibular
D1520	Space maintainer - removable, unilateral - per quadrant
D1526	Space maintainer - removable - bilateral, maxillary
D1527	Space maintainer - removable - bilateral, mandibular
D1551	Re-cement or re-bond bilateral space maintainer - maxillary
D1552	Re-cement or re-bond bilateral space maintainer - mandibular
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant
D1556	Removal of fixed unilateral space maintainer - per quadrant
D1557	Removal of fixed bilateral space maintainer - maxillary
D1558	Removal of fixed bilateral space maintainer - mandibular
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant
D1999	Unspecified preventive procedure, by report
D2140	Amalgam - one surface, primary or permanent
D2150	Amalgam - two surfaces, primary or permanent
D2160	Amalgam - three surfaces, primary or permanent
D2161	Amalgam - four or more surfaces, primary or permanent
D2330	Resin-based composite - one surface, anterior
D2331	Resin-based composite - two surfaces, anterior
D2332	Resin-based composite - three surfaces, anterior
D2335	Resin-based composite - four or more surfaces (anterior)
D2391	Resin-based composite - one surface, posterior
D2392	Resin-based composite - two surfaces, posterior
D2393	Resin-based composite - three surfaces, posterior
D2394	Resin-based composite - four or more surfaces, posterior
D2410	Gold foil - one surface
D2420	Gold foil - two surfaces
D2430	Gold foil - three surfaces
D2510	Inlay - metallic - one surface
D2520	Inlay - metallic - two surfaces
D2530	Inlay - metallic - three or more surfaces
D2542	Onlay - metallic - two surfaces
D2543	Onlay - metallic - three surfaces
D2544	Onlay - metallic - four or more surfaces
D2610	Inlay–porcelain/ceramic–one surface
D2620	Inlay–porcelain/ceramic–two surfaces
D2630	Inlay - porcelain/ceramic - three or more surfaces
D2642	Onlay - porcelain/ceramic - two surfaces
D2643	Onlay - porcelain/ceramic - three surfaces

D2644	Onlay - porcelain/ceramic - four or more surfaces
D2740	Crown - porcelain/ceramic
D2750	Crown - porcelain fused to high noble metal
D2751	Crown - porcelain fused to predominantly base metal
D2752	Crown - porcelain fused to noble metal
D2753	Crown - porcelain fused to titanium and titanium alloys
D2780	Crown - 3/4 cast high noble metal
D2781	Crown - 3/4 cast predominantly base metal
D2782	Crown - 3/4 cast noble metal
D2783	Crown - 3/4 porcelain/ceramic
D2790	Crown - full cast high noble metal
D2791	Crown - full cast predominantly base metal
D2792	Crown - full cast noble metal
D2794	Crown - titanium and titanium alloys
D2799	Interim crown - further treatment or completion of diagnosis necessary prior to final impression
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration
D2920	Re-cement or re-bond crown
D2928	Prefabricated porcelain/ceramic crown - permanent tooth
D2929	Prefabricated porcelain/ceramic crown - primary tooth
D2930	Prefabricated stainless steel crown - primary tooth
D2931	Prefabricated stainless steel crown - permanent tooth
D2932	Prefabricated resin crown
D2933	Prefabricated stainless steel crown with resin window
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth
D2940	Protective restoration
D2949	Restorative foundation for an indirect restoration
D2950	Core buildup, including any pins when required
D2951	Pin retention - per tooth, in addition to restoration
D2953	Each additional indirectly fabricated post - same tooth
D2954	Prefabricated post and core in addition to crown
D2955	Post removal
D2957	Each additional prefabricated post - same tooth
D2976	Band stabilization – per tooth
D2980	Crown repair necessitated by restorative material failure
D2981	Inlay repair necessitated by restorative material failure
D2982	Onlay repair necessitated by restorative material failure
D2983	Veneer repair necessitated by restorative material failure
D2989	Excavation of a tooth resulting in the determination of non-restorability
D2990	Resin infiltration of incipient smooth surface lesions
D2991	Application of hydroxyapatite regeneration medicament – per tooth
D2999	Unspecified restorative procedure, by report
D3110	Pulp cap - direct (excluding final restoration)
D3120	Pulp cap - indirect (excluding final restoration)
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development

D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)
D3310	Endodontic therapy, anterior tooth (excluding final restoration)
D3320	Endodontic therapy, premolar tooth (excluding final restoration)
D3330	Endodontic therapy, molar tooth (excluding final restoration)
D3331	Treatment of root canal obstruction; non-surgical access
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth
D3333	Internal root repair of perforation defects
D3346	Retreatment of previous root canal therapy - anterior
D3347	Retreatment of previous root canal therapy - premolar
D3348	Retreatment of previous root canal therapy - molar
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)
D3352	Apexification/recalcification - interim medication replacement
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)
D3355	Pulpal regeneration - initial visit
D3356	Pulpal regeneration - interim medication replacement
D3357	Pulpal regeneration - completion of treatment
D3410	Apicoectomy - anterior
D3421	Apicoectomy - premolar (first root)
D3425	Apicoectomy - molar (first root)
D3426	Apicoectomy (each additional root)
D3430	Retrograde filling - per root
D3450	Root amputation - per root
D3471	Surgical repair of root resorption - anterior
D3472	Surgical repair of root resorption - premolar
D3473	Surgical repair of root resorption - molar
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption - molar
D3910	Surgical procedure for isolation of tooth with rubber dam
D3911	Intraorifice barrier
D3920	Hemisection (including any root removal), not including root canal therapy
D3921	Decoronation or submergence of an erupted tooth
D3950	Canal preparation and fitting of preformed dowel or post
D3999	Unspecified endodontic procedure, by report
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant
D4249	Clinical crown lengthening - hard tissue
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant

D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant
D4263	Bone replacement graft - retained natural tooth - first site in quadrant
D4270	Pedicle soft tissue graft procedure
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant or edentulous tooth position in graft
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) - each additional contiguous tooth, implant or edentulous tooth position in same graft site
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) - each additional contiguous tooth, implant or edentulous tooth position in same graft site
D4341	Periodontal scaling and root planing - four or more teeth per quadrant
D4342	Periodontal scaling and root planing - one to three teeth per quadrant
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit
D4910	Periodontal maintenance
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)
D4999	Unspecified periodontal procedure, by report
D5110	Complete denture - maxillary
D5120	Complete denture - mandibular
D5130	Immediate denture - maxillary
D5140	Immediate denture - mandibular
D5211	Maxillary partial denture - resin base (including, retentive/clasping materials, rests, and teeth)
D5212	Mandibular partial denture - resin base (including, retentive/clasping materials, rests, and teeth)
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)
D5221	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)
D5222	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)
D5282	Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary
D5283	Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular
D5284	Removable unilateral partial denture - one piece flexible base (including retentive/clasping materials, rests,

	and teeth) - per quadrant
D5286	Removable unilateral partial denture - one piece resin (including retentive/clasping materials, rests, and teeth) - per quadrant
D5410	Adjust complete denture - maxillary
D5411	Adjust complete denture - mandibular
D5421	Adjust partial denture - maxillary
D5422	Adjust partial denture - mandibular
D5511	Repair broken complete denture base, mandibular
D5512	Repair broken complete denture base, maxillary
D5520	Replace missing or broken teeth - complete denture (each tooth)
D5611	Repair resin partial denture base, mandibular
D5612	Repair resin partial denture base, maxillary
D5621	Repair cast partial framework, mandibular
D5622	Repair cast partial framework, maxillary
D5630	Repair or replace broken retentive clasping materials - per tooth
D5640	Replace broken teeth - per tooth
D5650	Add tooth to existing partial denture
D5660	Add clasp to existing partial denture - per tooth
D5710	Rebase complete maxillary denture
D5720	Rebase maxillary partial denture
D5721	Rebase mandibular partial denture
D5725	Rebase hybrid prosthesis
D5730	Reline complete maxillary denture (direct)
D5731	Reline complete mandibular denture (direct)
D5740	Reline maxillary partial denture (direct)
D5741	Reline mandibular partial denture (direct)
D5750	Reline complete maxillary denture (indirect)
D5751	Reline complete mandibular denture (indirect)
D5760	Reline maxillary partial denture (indirect)
D5761	Reline mandibular partial denture (indirect)
D5765	Soft liner for complete or partial removable denture – indirect
D5850	Tissue conditioning, maxillary
D5851	Tissue conditioning, mandibular
D5863	Overdenture - complete maxillary
D5864	Overdenture - partial maxillary
D5865	Overdenture - complete mandibular
D5866	Overdenture - partial mandibular
D5999	Unspecified maxillofacial prosthesis, by report
D6010	Surgical placement of implant body: endosteal implant
D6011	Surgical access to an implant body (second stage implant surgery)
D6012	Surgical placement of interim implant body for transitional prosthesis: endosteal implant
D6040	Surgical placement: eposteal implant
D6050	Surgical placement: transosteal implant
D6051	Interim implant abutment placement
D6055	Connecting bar - implant supported or abutment supported
D6056	Prefabricated abutment - includes modification and placement

D6057	Custom fabricated abutment - includes placement
D6058	Abutment supported porcelain/ceramic crown
D6059	Abutment supported porcelain fused to metal crown (high noble metal)
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)
D6061	Abutment supported porcelain fused to metal crown (noble metal)
D6062	Abutment supported cast metal crown (high noble metal)
D6063	Abutment supported cast metal crown (predominantly base metal)
D6064	Abutment supported cast metal crown (noble metal)
D6065	Implant supported porcelain/ceramic crown
D6066	Implant supported crown - porcelain fused to high noble alloys
D6067	Implant supported crown - high noble alloys
D6068	Abutment supported retainer for porcelain/ceramic FPD
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)
D6072	Abutment supported retainer for cast metal FPD (high noble metal)
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)
D6074	Abutment supported retainer for cast metal FPD (noble metal)
D6075	Implant supported retainer for ceramic FPD
D6076	Implant supported retainer for FPD - porcelain fused to high noble alloys
D6077	Implant supported retainer for metal FPD - high noble alloys
D6080	Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure
D6082	Implant supported crown - porcelain fused to predominantly base alloys
D6083	Implant supported crown - porcelain fused to noble alloys
D6084	Implant supported crown - porcelain fused to titanium and titanium alloys
D6085	Interim implant crown
D6086	Implant supported crown - predominantly base alloys
D6087	Implant supported crown - noble alloys
D6088	Implant supported crown - titanium and titanium alloys
D6089	Accessing and retorquing loose implant screw - per screw
D6090	Repair implant supported prosthesis, by report
D6091	Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment
D6095	Repair implant abutment, by report
D6096	Remove broken implant retaining screw
D6097	Abutment supported crown - porcelain fused to titanium and titanium alloys
D6098	Implant supported retainer - porcelain fused to predominantly base alloys
D6099	Implant supported retainer for FPD - porcelain fused to noble alloys
D6100	Surgical removal of implant body
D6101	Debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure
D6102	Debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, including flap entry and closure

D6103	Bone graft for repair of peri-implant defect - does not include flap entry and closure
D6104	Bone graft at time of implant placement
D6105	Removal of implant body not requiring bone removal or flap elevation
D6110	Implant/abutment supported removable denture for edentulous arch - maxillary
D6111	Implant/abutment supported removable denture for edentulous arch - mandibular
D6112	Implant/abutment supported removable denture for partially edentulous arch - maxillary
D6113	Implant/abutment supported removable denture for partially edentulous arch - mandibular
D6114	Implant/abutment supported fixed denture for edentulous arch - maxillary
D6115	Implant/abutment supported fixed denture for edentulous arch - mandibular
D6116	Implant/abutment supported fixed denture for partially edentulous arch - maxillary
D6117	Implant/abutment supported fixed denture for partially edentulous arch - mandibular
D6118	implant/abutment supported interim fixed denture for edentulous arch– mandibular used when a period of healing is necessary prior to fabrication and placement of a permanent prosthetic
D6119	implant/abutment supported interim fixed denture for edentulous arch–maxillary used when a period of healing is necessary prior to fabrication and placement of a permanent prosthetic.
D6120	Implant supported retainer - porcelain fused to titanium and titanium alloys
D6121	Implant supported retainer for metal FPD - predominantly base alloys
D6122	Implant supported retainer for metal FPD - noble alloys
D6123	Implant supported retainer for metal FPD - titanium and titanium alloys
D6190	Radiographic/surgical implant index, by report
D6197	Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant
D6198	Remove interim implant component
D6210	Pontic - cast high noble metal
D6211	Pontic - cast predominantly base metal
D6212	Pontic - cast noble metal
D6214	Pontic - titanium and titanium alloys
D6240	Pontic - porcelain fused to high noble metal
D6241	Pontic - porcelain fused to predominantly base metal
D6242	Pontic - porcelain fused to noble metal
D6243	Pontic - porcelain fused to titanium and titanium alloys
D6245	Pontic - porcelain/ceramic
D6253	Interim pontic - further treatment or completion of diagnosis necessary prior to final impression
D6545	Retainer - cast metal for resin bonded fixed prosthesis
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis
D6600	Retainer inlay - porcelain/ceramic, two surfaces
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces
D6602	Retainer inlay - cast high noble metal, two surfaces
D6603	Retainer inlay - cast high noble metal, three or more surfaces
D6604	Retainer inlay - cast predominantly base metal, two surfaces
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces
D6606	Retainer inlay - cast noble metal, two surfaces
D6607	Retainer inlay - cast noble metal, three or more surfaces
D6608	Retainer onlay - porcelain/ceramic, two surfaces
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces
D6610	Retainer onlay - cast high noble metal, two surfaces

D6611	Retainer onlay - cast high noble metal, three or more surfaces
D6612	Retainer onlay - cast predominantly base metal, two surfaces
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces
D6614	Retainer onlay - cast noble metal, two surfaces
D6615	Retainer onlay - cast noble metal, three or more surfaces
D6740	Retainer crown - porcelain/ceramic
D6750	Retainer crown - porcelain fused to high noble metal
D6751	Retainer crown - porcelain fused to predominantly base metal
D6752	Retainer crown - porcelain fused to noble metal
D6753	Retainer crown - porcelain fused to titanium and titanium alloys
D6780	Retainer crown - 3/4 cast high noble metal
D6781	Retainer crown - 3/4 cast predominantly base metal
D6782	Retainer crown - 3/4 cast noble metal
D6783	Retainer crown - 3/4 porcelain/ceramic
D6784	Retainer crown - 3/4 titanium and titanium alloys
D6790	Retainer crown - full cast high noble metal
D6791	Retainer crown - full cast predominantly base metal
D6792	Retainer crown - full cast noble metal
D6793	Interim retainer crown - further treatment or completion of diagnosis necessary prior to final impression
D6930	Re-cement or re-bond fixed partial denture
D6980	Fixed partial denture repair necessitated by restorative material failure
D6999	Unspecified fixed prosthodontic procedure, by report
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated
D7220	Removal of impacted tooth - soft tissue
D7230	Removal of impacted tooth - partially bony
D7240	Removal of impacted tooth - completely bony
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications
D7250	Removal of residual tooth roots (cutting procedure)
D7251	Coronectomy - intentional partial tooth removal, impacted teeth only
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
D7280	Exposure of an unerupted tooth
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant
D7471	Removal of lateral exostosis (maxilla or mandible)
D7510	Incision and drainage of abscess - intraoral soft tissue
D7910	Suture of recent small wounds up to 5 cm
D7921	Collection and application of autologous blood concentrate product
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site
D7953	Bone replacement graft for ridge preservation - per site
D7971	Excision of pericoronal gingiva
D7999	Unspecified oral surgery procedure, by report
D8010	Limited orthodontic treatment of the primary dentition

D8020	Limited orthodontic treatment of the transitional dentition
D8030	Limited orthodontic treatment of the adolescent dentition
D8070	Comprehensive orthodontic treatment of the transitional dentition
D8080	Comprehensive orthodontic treatment of the adolescent dentition
D8090	Comprehensive orthodontic treatment of the adult dentition
D8210	Removable appliance therapy
D8220	Fixed appliance therapy
D8660	Pre-orthodontic treatment examination to monitor growth and development
D8670	Periodic orthodontic treatment visit
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))
D8681	Removable orthodontic retainer adjustment
D8698	Re-cement or re-bond fixed retainer - maxillary
D8699	Re-cement or re-bond fixed retainer - mandibular
D8701	Repair of fixed retainer, includes reattachment - maxillary
D8702	Repair of fixed retainer, includes reattachment - mandibular
D8999	Unspecified orthodontic procedure, by report
D9110	Palliative treatment of dental pain - per visit
D9210	Local anesthesia not in conjunction with operative or surgical procedures
D9211	Regional block anesthesia
D9212	Trigeminal division block anesthesia
D9215	Local anesthesia in conjunction with operative or surgical procedures
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia
D9222	Deep sedation/general anesthesia - first 15 minutes
D9223	Deep sedation/general anesthesia - each subsequent 15 minute increment
D9239	Intravenous moderate (conscious) sedation/analgesia - first 15 minutes
D9243	Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician
D9311	Consultation with a medical health care professional
D9610	Therapeutic parenteral drug, single administration
D9912	Pre-visit patient screening
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report
D9932	Cleaning and inspection of removable complete denture, maxillary
D9933	Cleaning and inspection of removable complete denture, mandibular
D9934	Cleaning and inspection of removable partial denture, maxillary
D9935	Cleaning and inspection of removable partial denture, mandibular
D9943	Occlusal guard adjustment
D9944	Occlusal guard - hard appliance, full arch
D9945	Occlusal guard - soft appliance, full arch
D9946	Occlusal guard - hard appliance, partial arch
D9990	Certified translation or sign-language services - per visit
D9991	Dental case management - addressing appointment compliance barriers
D9992	Dental case management - care coordination
D9995	Teledentistry - synchronous; real-time encounter
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review
D9997	Dental case management - patients with special health care needs
D9999	Unspecified adjunctive procedure, by report

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 beginning on page 11 in **your** certificate.

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.

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 infusion therapy **you** receive in an outpatient setting including but not limited to:

- A free-standing outpatient facility
- The outpatient department of a **hospital**

- A **physician's** office
- A home care **provider** in **your** home

See the *How To Contact **Us** For Help* section on page 5 in **your** certificate to learn how **you** can access the list of preferred infusion 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 on page 5 in **your** certificate 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.
- Used 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.

Chiropractic

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

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

frequency and duration.

Habilitation therapy services

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

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

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

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

Outpatient physical, occupational, and speech therapy

Eligible health services include:

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

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

10. Other Services and Conditions

Ambulance Service

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

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

Your plan 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

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

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

Coverage includes:

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

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

The following are not covered under this benefit:

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

Hearing Aids And Cochlear Implants And Related Services

Eligible health services include prescribed hearing aids and hearing aid services as described below. Eligible health services also include cochlear implants and the following related services and supplies:

- Fitting and dispensing services and ear molds necessary to maintain optimal fit of hearing aids

- Treatment related to cochlear implants, including:
  - Habilitation and rehabilitation necessary for educational gain
  - For cochlear implants, an external speech processor and controller
- Internal replacement of cochlear implants as medically or logically necessary

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

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

The following are not covered under this benefit:
- A replacement of:
  - A hearing aid that is lost or stolen
- Replacement parts or repairs for a hearing aid
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss
- Any ear or hearing exam performed by a physician who is not certified as an otolaryngologist or otologist
- Any tests, appliances and devices to:
  - Improve **your** hearing, including hearing aid batteries and auxiliary equipment
  - Enhance other forms of communication to make up for hearing loss or devices that simulate speech
- Hearing aids and Cochlear implants and related services, except as described above

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 disorder of amino and organic acids.

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 *Section 4 - Coverages – Prescription Drugs/Medications* beginning on page 49 in **your** certificate.

Orthotic devices

Eligible health services include the initial orthotic device and subsequent replacement that **your physician** orders and administers. This includes orthotic devices for complications of diabetes mellitus and any of the following complications involving the foot: Peripheral neuropathy with evidence of callus formation; or history of pre-ulcerative calluses; or history of previous ulceration; or foot deformity; or previous amputation of the foot or part of the foot; or poor circulation.

Obesity (Bariatric) Surgery

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

The following are not covered under any other benefit:

- Weight management treatment or drugs intended to decrease or increase body weight, control weight or treat obesity, including **morbid obesity**, except as described above and in *Section 4 - Coverages - Preventive care and wellness*, beginning on page 11, including preventive services for obesity screening and weight management interventions. This is regardless of the existence of other medical conditions. Examples of these are:
  - Liposuction, open vertical banded gastroplasty, laparoscopic vertical banded gastroplasty, open sleeve gastrectomy, and open adjustable gastric banding
  - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications
  - Hypnosis or other forms of therapy
  - Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement

Prosthetic Devices

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

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

Prosthetic device means:

- A medical device which replaces all or part of an internal body organ or an external body part lost or impaired as the result of disease, congenital defect or **injury**

Coverage includes:

- Repairing or replacing the original device unless **you** misuse or lose the device. Examples of these are: Repairing or replacing the original device **you** outgrow or that is no longer appropriate because **your** physical condition changed.
- Replacements required by ordinary wear and tear or damage.
- Instruction and other services (such as attachment or insertion) so **you** can properly use the device

The following are not covered under this benefit:

- Services covered under any other benefit

- Repair and replacement due to loss, misuse, abuse or theft

Autism Spectrum Disorder

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

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

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

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

Diabetic Equipment, Supplies And Education

Eligible health services include:

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

This coverage is for the treatment of insulin dependent (type I) and non-insulin dependent (type II) diabetes and the treatment of elevated blood glucose levels during pregnancy or another medical condition associated with elevated blood glucose levels. See the *Prescription Drugs/Medications* section beginning on page 49 for diabetic supplies that **you** can get at a **pharmacy**.

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

Jaw Joint Disorder Treatment

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

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

Behavioral Health

Mental health treatment

Eligible health services include the treatment of **mental health disorders** and gender identity 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 plan 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 plan 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 medical and surgical services provided by a **physician** and **hospital**. This includes inpatient immunosuppressive medications and costs for organ procurement which includes travel, surgery, and compatibility testing.

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**

Organ Transplant Travel Services

Travel expenses incurred by **you** in connection with a pre-approved organ/tissue transplant are covered subject to the following conditions and limitations. Travel expenses are limited to $10,000. Organ transplant travel benefits are not available for cornea transplants. Benefits for transportation, lodging and food are available only for the recipient of a pre-approved organ/tissue transplant from a transplant facility. The term recipient is defined to include a Member receiving authorized transplant related services during any of the following:

1. Evaluation,
2. Candidacy,
3. Transplant event, or
4. Post-transplant care.

All claims filed for travel expenses must include detailed receipts, except for mileage. Transportation mileage will be calculated by the Third Party Claim Administrator based on the home address of the Member and the transplant site. Travel expenses for the Member receiving the transplant will include

charges for:

1. Transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility);
2. Transportation to and from the transplant site in a personal vehicle will be reimbursed at 37.5 cents per mile when the transplant site is more than 60 miles one way from the Member's home.
3. Lodging while at, or traveling to and from the transplant site;
4. Food while at, or traveling to and from the transplant site.

In addition to the Member being covered for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany the Member. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver.

Treatment Of Infertility

Basic infertility services

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

- To diagnose and evaluate the underlying medical cause of **infertility**.

The following are not covered under the infertility services benefits:

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

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** plan
- 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
- 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 plan 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 on page 5 in **your** certificate 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 on page 5 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 plan. **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 Plan

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

- They are listed in *Section 4 – Coverages* beginning on page 11
- They are not listed in *Section 5 – General Exclusions* beginning on page 57
- They are not beyond any limits in the Schedule of Benefits

Your pharmacy services are covered when **you** follow the plan's general rules:

- **You** need a **prescription** from **your prescriber**.
- **Your** drug needs to be **medically necessary**. See *Section 3 - Medical Necessity, Referral And Preauthorization Requirements* beginning on page 9.
- **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 *How to Request A Medical Exception* section on page 56 for more information.

Prescription Drugs covered by this plan 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 on page 5 in **your** certificate 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 plan, 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 plan.

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 plan, 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/media/150299/download.

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 *Section 4 - Coverages - Specific Conditions - Diabetic Equipment, Supplies And Education*, page 44 in **your** certificate for coverage of blood glucose meters and insulin pumps and for diabetic supplies that **you** can get from other **providers**.

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

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

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

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

For purposes of this benefit, “low protein modified food product” means foods specifically formulated to have less than one gram of protein per serving and are intended to be used under the direction of a

physician for the dietary treatment of any inherited metabolic disease. Low protein modified food products do not include foods that are naturally low in protein.

Orally Administered Anti-Cancer Drugs, Including Chemotherapy Drugs

Eligible health services include any drug prescribed for the treatment of cancer if it is recognized for treatment of that indication in a standard reference compendium or recommended in the medical literature even if the drug is not approved by the FDA for a particular indication. Coverage for oral anti-cancer **prescription drugs** will not be less favorable than for intravenously or injected anti-cancer **prescription drugs**. **Your prescriber** or **your** pharmacist may need to get approval from **us** before **we** will agree to cover the drug for **you**. See the *Preauthorization* section beginning on page 9 in **your** certificate 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:
  - 23rd day after the date a 30-day supply is dispensed
  - 45th day after the date a 60-day supply is dispensed
  - 68th 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, but MAY be covered under another benefit in **your** plan:

- 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 *Section 4 - Coverages – Prescription Drugs/Medications* beginning on page 49
- Implantable drugs and associated devices except where stated above
- **Infertility**
  - **Prescription drugs** used primarily for the treatment of **infertility** except where stated in *Section 4 - Coverages – Treatment Of Infertility*, beginning on page 48
- 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** plan.
  - 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 *Section 4 - Coverages – Tobacco Cessation Prescription And Over-The-Counter Drugs- Prescription Drugs/Medications* beginning on page 53.
- 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 plan'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 plan.

Your prescription drug costs are based on:

- The type of **prescription you** use
- Where **you** fill **your prescription**

The plan 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 on page 5 in **your** certificate 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 on page 5 in **your** certificate 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 on page 5 in **your** certificate.

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.

IMPORTANT NOTES:

- If **we** make a prescription drug formulary change that removes or restricts a drug, **you** will be notified at least 60 days prior to the change.
- **We** will respond to the Medical Exception request within 72 hours of receiving the request and clinical documentation, except in the case of urgent requests, which will be responded to within 24 hours of receiving the request and clinical documentation.
- If **your** request is denied, **you** and **your provider** will receive notice in writing with medical/pharmacological reasoning, and information about appealing this decision.
- If **your** request is approved, **you** and **your provider** will receive notice in writing. Approval is effective throughout the duration of the current plan year. **We** may request a new request upon renewal of the same plan for subsequent plan years.

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.

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

SECTION 5 – GENERAL EXCLUSIONS

We already told **you** about the many health care services and supplies that are eligible for coverage under **your** plan in *Section 4 – Coverages* beginning on page 11. 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** plan.

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** plan except as described in *Section 4 – Coverages* beginning on page 11 of this certificate or by a rider or amendment included with this certificate:

Acupuncture
Your plan 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
- Tobacco use disorders and nicotine dependence except as described in *Section 4 - Coverages - Preventive Screening And Counseling Services* beginning on page 13
- Pathological gambling, kleptomania, and pyromania

Blood, Blood Plasma, Synthetic Blood, Blood Derivatives Or Substitutes, (Except As Described In *Section 4 - Coverages – In Patient and Outpatient Hospital Services*, beginning on page 16)
Examples of these are:

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

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

Clinical Trial Therapies (Experimental Or Investigational)

- **Your** plan does not cover clinical trial therapies (**experimental or investigational**), except where described in the *Section 4 - Coverages - Clinical Trial Therapies (Experimental Or Investigational)*

section beginning on page 40.

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 *Section 4 – Coverages*, beginning on page 11

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

Educational Services

Examples of those services are:

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

Examinations

Any health or dental examinations needed:

- Because a third party requires the exam. Examples include examinations to get or keep a job, or examinations required under a labor agreement or other contract.
- Because a court order requires it.
- To buy insurance or to get or keep a license.

- To travel.
- To go to a school, camp, or sporting event, or to join in a sport or other recreational activity.

Experimental Or Investigational

- **Experimental or investigational** drugs, devices, treatments or procedures unless otherwise covered under clinical trial therapies (**experimental or investigational**) or covered under clinical trials (routine patient costs)

Please see *Section 8 – When **You** Have a Complaint or Appeal* beginning on page 70 and the Health Care Insurer Appeals Process packet included with **your** certificate 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
- 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 mellitus and any of the following complications involving the foot: Peripheral neuropathy with evidence of callus formation; or history of pre-ulcerative calluses; or history of previous ulceration; or foot deformity; or previous amputation of the foot or part of the foot; or poor circulation. See the *Other Services and Conditions* section for more information.

Gene-Based Therapies

- Genetic testing and therapy including germ line and somatic unless determined Medically Appropriate by the Plan for the purpose of making treatment decisions.

Growth/Height care

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

Maintenance Care

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

Medical Supplies – Outpatient Disposable

- Any outpatient disposable supply or device. These items are usually included in the cost of other services and are not billed separately. Examples of these include:

- Sheaths
- Bags
- Support hose
- Bandages
- Bedpans
- Syringes, except for treatment of diabetes
- Blood or urine testing supplies, except for treatment of diabetes
- Other home test kits
- Splints
- Neck braces
- Compresses
- Other devices not intended for reuse by another patient

Orthotic Devices

- Repair and replacement due to loss, misuse, abuse or theft

Other Primary Payer

- When applicable federal law requires Medicare to be the primary payer for an eligible health service, this plan will not pay the portion of the allowable expense for which Medicare is responsible as the primary payer. This exclusion does not apply when applicable federal law requires this plan to be the primary payer and Medicare to be the secondary payer.

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 *Section 4 - Coverages – Inpatient and Outpatient Hospital Services* beginning on page 16

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, unless they are a **health care provider** in **your provider network**

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 plan.

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, except the use of an audio-only telephone encounter between an enrollee who has an existing relationship with a health care provider or provider group if both of the following apply:
  - An audio-visual telehealth encounter is not reasonably available due to the enrollee's functional status, the enrollee's lack of technology or telecommunications infrastructure limits, as determined by the health care provider.
  - The telehealth encounter is initiated at the request of the enrollee or authorized by the enrollee before the telehealth encounter.
- 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 certificate:

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).

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 plan

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.

IMPERIAL INSURANCE COMPANIES

SECTION 6 – WHO PROVIDES THE CARE

Just as the starting point for coverage under **your** plan 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** plan.

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 *Section 4 – Coverages* beginning on page 11.
- Urgent care – refer to the description of **emergency services** and urgent care in *Section 4 – Coverages* beginning on page 11 and to the Schedule of Benefits.
- **Network provider not reasonably available** – **You** can get **eligible health services** under **your** plan 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 on page 5 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 customary 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 on page 5 for assistance.
- Transplants – see the description of transplant services in *Section 4 – Coverages* beginning on page 11

You may select a **network provider** from the provider **directory** through **our** website at www.Imperialhealthplan.com. See the *How To Contact **Us** For Help* section on page 5. **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 plan owes.

Your PCP

For **you** to receive the network level of benefits, **eligible health services** must be accessed through **your PCP** or another **network provider**. They will provide **you** with primary care.

A **PCP** can be any of the following **providers** available under **your** plan:

- 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 *Section 8 – When **You** Have a Complaint or Appeal* on page 70.

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 at www.Imperialhealthplan.com. See the *How To Contact **Us** For Help* section on page 5 to make a change.

What Happens If You Do Not Select A PCP

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

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

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

- The **provider you** have now is not in the network
- **You** are already a member of Imperial and **your provider** stops being in **our** network

However, in some cases, **you** may be able to keep going to **your** current **provider** to complete a treatment or to have treatment that was already scheduled. This is called continuity of care.

	If You Are A New Enrollee And Your Provider Is An Out-Of-Network Provider	**When Your Provider Stops Participation With Us**
Request for approval	**You** need to complete a Transition of Coverage Request form and send it to **us**. **You** can get this form by calling the number on **your** ID card.	**You** or **your provider** should call **us** for approval to continue any care.
Length of transitional period	Care will continue during a transitional period, usually 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 Serious and Complex Condition, Are Undergoing a Course of Institutional or Inpatient Care, or Are Scheduled to Undergo Nonelective Surgery And Your Provider Stops Participation With Imperial
Request for approval	**Your provider** should call **us** for approval to continue any care. **You** can call Member Services at the toll-free number on **your** ID card for information on continuity of care.
Length of transitional period	Care will continue during a transitional period for up to 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
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 Your Provider Stops Participation With Imperial
Request for approval	**Your provider** should call **us** for approval to continue any care.
	You can call Member Services at the toll-free number on **your** ID card for information on continuity of care.
Length of transitional period	Care will continue during a transitional period 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 7 – 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**.

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 *Section 3 – Medical Necessity Referral, And Preauthorization Requirements* beginning on page 9.
- When Imperial requires **preauthorization**, it was requested, **we** refused it, and **you** get an **eligible health service** without **preauthorization**. See *Section 3 – Medical Necessity Referral, And Preauthorization Requirements* beginning on page 9.
- When **you** get an **eligible health service** without a **referral** when **your** plan requires a **referral**. See *Section 3 – Medical Necessity Referral, And Preauthorization Requirements* beginning on page 9.
- When **you** get an **eligible health service** from someone who is not a **network provider**. See *Section 6 – Who Provides The Care* beginning on page 63.

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** coverage. 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 plan.

Coordination of Benefits

Some people have health coverage under more than one health plan. If **you** do, **we** will work with **your** other plan to decide how much each plan pays. This is called coordination of benefits (COB).

Key terms

Here are some key terms **we** use in this section. These will help **you** understand this COB section.

Allowable expense means a health care expense that any of **your** health plans cover.

In this section when **we** talk about "plan" through which **you** may have other coverage for health care expenses we mean:

- **Group** or non-group, blanket, or franchise health insurance policies issued by insurers, HMOs, or health care service contractors
- Labor-management trustee plans, labor organization plans, employer organization plans, or employee benefit organization plans
- An automobile insurance policy
- Medicare or other government benefits
- Any contract that **you** can obtain or maintain only because of membership in or connection with a particular organization or group

How COB works

- When this is **your** primary plan, **we** pay **your** medical claims first as if there is no other coverage.
- When this is **your** secondary plan:
    - **We** pay benefits after the primary plan and reduce **our** payment based on any amount the primary plan paid
    - Total payments from this plan and **your** other coverage will never add up to more than 100% of the allowable expenses

Determining who pays

The basic rules are listed below. Reading from top to bottom the first rule that applies will determine which plan is primary and which is secondary. Contact **us** if you have questions or want more information.

A plan that does not contain a COB provision is always the primary plan.

COB Rule	Primary Plan	Secondary Plan
Non-dependent or dependent	Plan covering **you** as an employee or retired employee, (not as a dependent)	Plan covering **you** as a dependent
Child – parents married or living together	Plan of parent whose birthday (month and day) is earlier in the year (Birthday rule)	Plan of parent whose birthday is later in the year
Child – parents separated, divorced, or not living together	• Plan of parent responsible for health coverage in court order • Birthday rule applies if both parents are responsible or have joint custody in court order • Custodial parent's plan if there is no court order	• Plan of other parent • Birthday rule applies (later in the year) • Non-custodial parent's plan
Child – covered by individuals who are not parents (i.e., stepparent or grandparent)	Same rule as parent	Same rule as parent
Active or inactive employee	Plan covering **you** as an active employee (or dependent of an active employee)	Plan covering **you** as a laid off or retired employee (or dependent of a former employee)
Consolidated Omnibus Budget Reconciliation Act (COBRA) or state continuation	Plan covering **you** as an employee or retiree (or dependent of an employee or retiree)	COBRA or state continuation coverage
Longer or shorter length of coverage	Plan that has covered **you** longer	Plan that has covered you for a shorter period of time
Other rules don't apply	Plans share expenses equally	Plans share expenses equally

How COB works with Medicare

If **your** other coverage is under Medicare, federal laws explain whether Medicare will pay first or second. COB with Medicare will always follow federal requirements. Contact **us** if you have any questions about this.

When **you** are enrolled in Medicare Part A, B, or D, **we** coordinate the benefits **we** pay with the benefits that Medicare pays. Sometimes, this plan pays benefits before Medicare pays and sometimes, this plan pays benefits after Medicare. Notify **us** immediately if **you** enroll in Medicare while covered under this plan.

Other health coverage updates – contact information

You should contact **us** if **you** have any changes to **your** other coverage. **We** want to be sure **our** records are accurate so **your** claims are processed correctly.

Our rights

We have the right to:

- Release or obtain any information **we** need for COB purposes, including information **we** need to recover any payments from **your** other health plans

- Reimburse another health plan that paid a benefit **we** should have paid
- Recover any excess payment from a person or another health plan, if **we** paid more than **we** should have paid

SECTION 8 – WHEN YOU HAVE A COMPLAINT OR AN APPEAL

Start with Customer Service
We are here to listen and help. If **you** have a concern regarding a person, a service, the quality of care, contractual benefits, or a rescission of coverage, **you** can call **our** toll-free number and explain **your** concern to one of **our** Member Service representatives. Please call **us** at the Member Service Toll-Free Number that appears on **your** ID Card, explanation of benefits or claim form.

We will do **our** best to resolve the matter on **your** initial contact. If **we** need more time to review or investigate **your** concern, **we** will get back to **you** as soon as possible, but in any case, within 30 days.

If **you** are not satisfied with the results of a coverage decision, **you** can start the appeals procedure.

We want **you** to be completely satisfied with the care **you** receive. That is why **we** have established a process for addressing **your** concerns and solving **your** problems. The Appeals Process Information Packet ("Appeal Packet") describes the process by which Members may obtain information and submit concerns regarding service, benefits, and coverage. For more information, see the Appeals Process Information Packet ("Appeal Packet").

We will provide **you** a copy of the Appeal Packet when **you** first receive **your** certificate, and within 5 business days after **we** receive **your** request for an appeal. When **your** insurance coverage is renewed, we must also send **you** a separate statement to remind **you** that **you** can request another copy of this packet. **We** will also send a copy of this packet to **you** or **your** treating Provider at any time upon request. Just call Member Services at the toll-free number that appears on **your** ID card.

SECTION 9 – 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 plan ends when:

- This plan is no longer available
- **You** ask to end coverage
- The **contract holder** asks to end coverage
- **You** are no longer eligible for coverage
- **Your** work ends
- **You** stop making required **contributions** if any apply
- **We** end **your** coverage
- **You** start coverage under another medical plan offered by **your** employer

We will provide, or ensure that **you** receive, notice of cancellation or nonrenewal within the time required by applicable law. When 60 days' advance notice is required, the notice will tell **you** why **your** coverage is ending.

When Coverage Will End For Any Dependents

Dependent coverage ends when:

- A dependent is no longer eligible for coverage
- **You** stop making any required **contribution** toward the cost of your dependent's coverage
- **Your** coverage ends for any of the reasons listed above except:
    - **You** enroll under a group Medicare plan **we** offer
        - But dependent coverage will end when **your** Medicare plan coverage ends
- This plan no longer allows coverage for domestic partners or civil unions
- The domestic partnership or civil union ends
    - **You** will need to complete a Declaration of Termination of Domestic Partnership

Dependent coverage if you die

Coverage for dependents may continue for some time after **your** death. See the *Special coverage options after your coverage ends* section below for more information.

When We Would End Coverage

We may end **your** coverage for fraud or intentional misrepresentation of material fact, as permitted by applicable law. If **we** rescind **your** coverage, **we** will provide the advance written notice described in Section 10.

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

Special coverage options after your coverage ends

When coverage may continue under the plan

This section explains options **you** may have after **your** coverage ends under this plan. **Your** individual situation will determine what options **you** will have. Contact the **contract holder** to see what options apply to **you**.

In some cases, **premium** payment is required for coverage to continue. **Your** coverage will continue under the plan as long as the **contract holder** and **we** have agreed to do so. It is the **contract holder's** responsibility to let **us** know when **your** work ends. If the **contract holder** and **we** agree in writing, **we** will extend the limits.

Consolidated Omnibus Budget Reconciliation Act (COBRA) rights

The federal COBRA law usually applies to employers of **group** sizes of 20 or more and gives employees and most of their **covered dependents** the right to keep their health coverage for 18, 29 or 36 months after a qualifying event. The qualifying event is something that happens that results in **you** losing **your** coverage.

The qualifying events are:

- **Your** active employment ends for reasons other than gross misconduct
- **Your** working hours are reduced
- **You** divorce or legally separate and are no longer responsible for dependent coverage
- **You** become entitled to benefits under Medicare
- **Your** covered dependent children no longer qualify as dependents under the plan
- **You** die
- **You** are a retiree eligible for retiree health coverage and **your** former employer files for bankruptcy

Talk with **your** employer if you have questions about COBRA or to enroll.

Continuation of coverage (state continuation)

If **you** have been covered under this plan for at least 3 months before a qualifying event, continuation of coverage may give **you** the right to keep **your** health coverage. This continuation of coverage provision applies to employers with an average of at least one but fewer than 20 eligible employees during the preceding calendar year. Talk to **your** employer if **you** have any questions about this.

Here are the qualifying events that trigger continuation of coverage and who is eligible for continuation.

Qualifying event causing loss of coverage	**Covered persons eligible for continued coverage**
Your working hours are reduced so that **you** no longer qualify for coverage	**You** and **your** dependents
Your active employment ends	**You** and **your** dependents
You divorce or legally separate and are no longer responsible for dependent coverage	**Your** dependents
You become entitled to benefits under Medicare	**Your** dependents
Your covered dependent children no longer qualify as dependents under the plan	**Your** dependent children
You die	**Your** dependents
You are a retired enrollee, their spouse or dependent and, within one year before or after, **your** former employer files for bankruptcy	**You** and **your** dependents

Notice of rights to continue coverage

Your employer must notify **you** in writing within 30 days after a qualifying event of **your** rights to continue coverage.

What you need to do to continue coverage

You or **your** qualified dependent must:

- Elect continuation coverage in writing within 60 days after the date of the notice
- Submit the first month's **premium** and administrative fee to **your** employer within 45 days after the date of the election to continue coverage

If **you** take these steps, coverage must be continued as though there was no interruption.

If **your** employer does not provide complete, accurate and timely notice of **your** right to continue coverage, **you** have 120 days after the date of the notice to elect continuation coverage and to pay the required **premium** and administrative fee.

Notice of change in premium

If the plan is renewed during **your** or **your** qualified dependent's eligibility period for continuation coverage, **your** employer must notify **you** or **your** qualified dependent of any change to the premium due at least 30 days prior to the effective date of the change.

Continuation of coverage ends on the earliest of the following dates:

- 18 months after the date the continuation coverage begins
- The date coverage would end if **you** do not pay **your premium** and administrative fee
- The date **you** or any qualified dependent is eligible for Medicare, Medicaid or obtains other health care coverage, with respect only to that person
- The date **your** employer terminates coverage under the plan for all employees. If the employer replaces the plan, **you** and any qualified dependents have the right to coverage under the new plan for any remaining eligibility period
- The date a dependent child would lose eligibility under the plan due to age

If another qualifying events occurs during the 18-month continuation period, a qualified dependent is eligible to continue coverage for an additional 18 months.

Continuation of coverage for a dependent with disability

You have the right to continue coverage for an additional 11 months for a qualified dependent if **your** disabled dependent when:

- **Your** disabled dependent Is determined to have a disability under Title II or Title XVI of the Social Security Act
- **You** provide the written determination of disability from the Social Security Administration to **your** employer within 60 days after the determination and before the end of the 18-month continuation period

We may charge **your** employer up to 150% of the group rate during the 11-month disability extension.

You or your qualified dependent must notify your employer within 30 days if the Social Security Administration determines the qualified dependent no longer has a disability.

Continuation of coverage for military reserve or National Guard active duty

If **you** are called to active duty and **your** employment is terminated either after or during active duty, the termination is considered a separate qualifying event. It is considered separately from any other qualifying event that occurred when **you** were called to active duty. **You** are eligible for a new 18-month benefit period beginning on the later of:

- The date active duty ends, or
- The date employment terminates

The following events are also considered separately from any qualifying event that occurred when **you** were called to active duty:

- **You** die during the period of active duty
- **You** divorce or legally separate
- **Your** dependent child no longer meets the eligibility requirements for a dependent under the plan

If the continuation of coverage is terminated because **you** are covered by a US Department of Defense plan, the continuation period **you** are entitled to under the employer's plan is paused. You may elect to continue coverage under the employer's plan within 63 days after the termination of the Department of Defense plan with coverage retroactive to the date of the termination of the Department of Defense plan.

Continuation of coverage for other reasons

To request an extension of coverage, just contact **us**.

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

You have the right to extend coverage for **your** dependent child beyond plan age limits if the child is not able to be self-supporting because of mental or physical disability and depends mainly (more than 50% of their income) on **you** for support.

The right to coverage will continue only as long as a **physician** certifies that **your** child still is disabled.

We may ask **you** to send **us** proof of the disability within 31 days of the date coverage would have ended. Before **we** extend coverage, **we** may ask that **your** child get a physical exam. **We** will pay for that exam.

We may ask **you** to send proof that **your** child is disabled after coverage is extended. **We** won't ask for this proof more than once a year. **You** must send it to us within 31 days of **our** request. If **you** don't, **we** can end coverage for **your** dependent child.

How you can extend coverage when getting inpatient care when coverage ends

Your coverage may be extended if **you** are getting inpatient care in a **hospital** or **skilled nursing facility** when coverage ends.

Benefits are extended for the condition that caused the **hospital** or **skilled nursing facility stay** or for complications from the condition. Benefits aren't extended for other medical conditions.

You can continue to get care for this condition until the earliest of:

- When **you** are discharged
- When **you** no longer need inpatient care
- When **you** become covered by another health benefits plan

How you can extend coverage for dental work when coverage ends

Your dental coverage may end while **you** or **your** dependent are in the middle of treatment. The plan does not cover dental services that are given after **your** coverage ends. There is an exception. The plan will cover the following **covered services** if they are ordered while **you** were covered by the plan, and installed within 30 days after **your** coverage ends:

- Inlays
- Onlays
- Crowns
- Removable bridges
- Cast or processed restorations
- Dentures
- Fixed partial dentures (bridges)
- Root canals

Ordered means:

- For a denture: the impressions from which the denture will be made were taken
- For a root canal: the pulp chamber was opened
- For any other item: the teeth which will serve as retainers or supports, or the teeth which are being restored:
    - Must have been fully prepared to receive the item
    - Impressions have been taken from which the item will be prepared

Converting from a group to an individual health plan

When the **group** coverage terminates, **you** and **your** dependents who were covered under this group plan have the right to continue coverage under **our** individual conversion plan.

When do conversion rights apply?

Conversion right apply if:

- **Your** active employment ends
- **You** and **your** spouse divorce, legally separate or **your** marriage is annulled. This applies to the surviving spouse and, at the option of the spouse, the child(ren) for whom the spouse has responsibility for care and support
- **Your** covered dependent children no longer qualify as dependents under the plan
- **You** die. This applies to the surviving spouse and, at the option of the spouse, the child(ren) for whom the spouse has responsibility for care and support.

Conversion rights do not apply, and the conversion plan will terminate if:

- **You** fail to pay **premium** or **premiums** are not received in a timely manner
- **You** are eligible for Medicare coverage, or eligible for, or covered by other similar insurance which together with the conversion coverage would constitute overinsurance

How you apply for a conversion plan

To apply **we** must receive **your** application and **your** first **premium** payment within 31 days after **your group** plan ends.

SECTION 10 – GENERAL PROVISIONS – OTHER THINGS YOU SHOULD KNOW

Administrative Provisions

How We Will Interpret This Certificate

We prepared this certificate according to federal and state laws, as applicable. **We** will interpret the certificate according to these laws.

How We Administer This Plan

We administer this plan to comply with all applicable laws and regulations. **We** also apply policies and procedures **we've** developed to administer this plan.

To the fullest extent permitted by law, **we** have exclusive discretion to determine all matters relating to eligibility, coverage, and benefits under this plan.

We have complete authority to review all denied claims for benefits under this plan. In doing so **we** will:

- Determine whether and to what extent **you** are entitled to benefits
- Interpret any disputed or unclear terms under this plan

We will have properly applied **our** authority unless **we** abuse **our** discretion. **Our** decisions are conclusive and binding. Also, **you** are bound by **our** interpretation of this certificate when **we** administer **your** coverage.

See *Section 8 – When **You** Have a Complaint or Appeal*, page 70 if **you** disagree with a determination that **we** have made.

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

Your coverage is defined by the group agreement. This document may have amendments or riders too. Under certain circumstances, **we**, the **contract holder**, or an **applicable law** may change **your** plan. 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** plan. No other person – including **your provider** – can do this.

Financial Sanctions Exclusions

If coverage provided under this plan 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 https://ofac.treasury.gov/sanctions-list-service.

Legal Action

You must complete the internal appeal process before **you** take any legal action against **us** for any expense or bill. See *Section 8 – When **You** Have a Complaint or Appeal* on page 70 in **your** certificate. **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 plan.

Following The Law

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

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:

- Rescission of coverage
- Loss of coverage going forward
- Denial of benefits
- Recovery of amounts **we** already paid

We also may report fraud to criminal authorities. Rescission means **you** lose coverage both going forward

and backward. If **we** paid claims for **your** past coverage, **we** will want the money back.

You have special rights if **we** rescind your coverage:

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

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 plan does not cover. If **we** do, **we** can require the person **we** paid – **you** or **your provider** – to return what **we** paid. If **we** do not seek recovery of the overpayment, **we** have the right to reduce any future benefit payments by the amount **we** paid by mistake.

Your Health Information

We will protect **your** health information. **We** use and share it to help **us** process **your** claims and manage **your** plan . **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 plan , **you** agree to let **your providers** share **your** information with **us**. **We** will need information about **your** physical and mental condition and care.

SECTION 11 – DEFINITIONS

Imperial
Imperial Insurance Companies, 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 plan. These may change over time.

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

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

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

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

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

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

Contract Holder
The employer or other entity that has entered into the **Group Agreement** with **us** and is responsible for administering the plan on behalf of the **Group**, including providing eligibility and enrollment information and paying **premiums** due under the **Group Agreement**.

Contribution

The amount, if any, that the **contract holder** requires **you** to pay toward the cost of **your** coverage or **your** dependent's coverage.

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 plan.

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 plans that include a **deductible**, this is the amount **you** pay for **eligible health services** per year before **your** plan 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.

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** plan. The most up-to-date **directory** for **your** plan appears on **our** website at www.Imperialhealthplan.com. See the *How To Contact **Us** For Help* section on page 5. When searching for **providers**:

- Make sure **you** are searching for **providers** that participate in **your** specific plan
- Remember, some **network providers** may only be considered **network providers** for certain Imperial plans
- Search under dental plans for network **dental providers**

Drug Guide

A list of **prescription drugs** and OTC drugs and devices established by **us** or an affiliate provides coverage, approves payment and encourages or offers incentives. It does not include all **prescription drugs** and OTC drugs and devices. This list can be reviewed and changed by **us** or an affiliate. A copy of the **drug guide** is available at **your** request, or **you** can find it on **our** website at www.Imperialhealthplan.com. See the *How To Contact **Us** For Help* section on page 5.

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 member's coverage begins under this plan. The date dependents' coverage begins under this plan as noted in **our** records.

Eligible Health Services

The health care services and supplies listed as **covered benefits** in *Section 4 – Coverages* beginning on page 11. Eligible health services may have limits. See the Schedule of Benefits.

Emergency Medical Condition

Emergency condition is the onset of a medical condition that manifests itself by symptoms of sufficient severity, INCLUDING SEVERE PAIN, SUCH THAT A PRUDENT LAYPERSON WHO POSSESSES AN AVERAGE KNOWLEDGE OF HEALTH AND MEDICINE COULD REASONABLY EXPECT the absence of immediate medical attention to result in any of the following:

- Serious jeopardy to the patient's health, INCLUDING MENTAL HEALTH, (or, with respect to a pregnant woman, the health of the woman or her unborn child)
- Serious impairment to A BODILY FUNCTION OF THE PATIENT.
- Serious dysfunction of any bodily organ or part OF THE PATIENT.
- HARM TO THE PATIENT OR OTHERS.

Emergency Services

A **condition or symptom** that a prudent layperson would believe requires **immediate treatment** to:

1. Preserve your life; or
2. Prevent serious impairment to your bodily functions, organs, or parts; or
3. Prevent placing your physical or mental health in serious jeopardy.

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

Group

The employees and other eligible persons covered under the **Group Agreement** issued to the **Contract Holder**.

Group Agreement

The agreement between **us** and the **Contract Holder** that establishes the terms under which coverage is provided to eligible employees and dependents of the **Group.**

Health Professional

A person who is licensed, certified or otherwise authorized by **applicable law** to provide health care services to the public. For example, **physicians**, nurses, and physical therapists.

Home Health Care Agency

An agency licensed, certified or otherwise authorized by **applicable law** to provide home health care services, such as skilled nursing and other therapeutic services.

Home Health Care Plan

A plan of services prescribed by a **physician** or other health care practitioner to be provided in the home setting. These services are usually provided after **your** discharge from a **hospital**.

Hospice Care

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

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

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

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

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

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

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

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

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

Intensive Outpatient Program (IOP)

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

Jaw Joint Disorder

This is:

- A Temporomandibular Joint (TMJ) dysfunction or any similar disorder of the jaw joint
- A Myofascial Pain Dysfunction (MPD) of the jaw
- Any similar disorder in the relationship between the jaw joint and the related muscles and nerves

L.P.N.

A licensed practical nurse or a licensed vocational nurse.

Mail Order Pharmacy

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

Maximum Out-Of-Pocket Limit

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

Medically Necessary, Medical Necessity

Health care services that meet all the following criteria:

- Ordered by a physician;
- Not more extensive than required to meet the basic health needs;
- Consistent with the diagnosis of the condition for which they are being utilized;
- Consistent in type, frequency and duration of treatment with scientifically based guidelines by the medical-scientific community in the United States of America;
- Required for purposes other than the comfort and convenience of the patient or provider;
- Rendered in the least intensive setting that is appropriate for their delivery; and
- Have demonstrated medical value.

Mental Health Disorder

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

Morbid Obesity

This means the body mass index is well above the normal range (greater than 40 kilograms per meter squared; or equal to or greater than 35 kilograms per meter squared) and severe medical conditions may

also be present, such as:

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

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

Nationally Recognized Clinical Practice Guidelines

Means evidence-based clinical practice guidelines that both:

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

Negotiated Charge

For health coverage, this is either*:*

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

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

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

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

Some of these arrangements are called:

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

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

For **prescription drug** services from a **network pharmacy***:*
The amount **we** established for each **prescription drug** obtained from a **network pharmacy** under this plan. 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 plan.

Network Provider
A **provider** listed in the **directory** for **your** plan.

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 payable to **us** under the Group Agreement for coverage under the plan.

Prescriber

Any **provider** acting within the scope of his/her license, who has the legal authority to write an order for outpatient **prescription drugs**.

Prescription

As to hearing care:
A written order for the dispensing of **prescription** electronic hearing aids by otolaryngologist, otologist or audiologist.

As to **prescription drugs**:
A written order for the dispensing of a **prescription drug** by a **prescriber**. If it is a verbal order, it must promptly be put in writing by the **network pharmacy**.

As to vision care:
A written order for the dispensing of **prescription** lenses or **prescription** contact lenses by an ophthalmologist or optometrist.

Prescription Drug

An FDA approved drug or biological which can only be dispensed by **prescription**.

Primary Care Physician (PCP)

A **physician** who:

- The **directory** lists as a **PCP** and is selected by a person from the list of **PCPs** in the **directory**
- Supervises, coordinates and provides initial care and basic medical services to a person as a family care **physician**, an internist or a pediatrician
- Initiates **referrals** for **specialist** care
- Maintains continuity of patient care
- Is shown on **our** records as **your PCP**

Provider

A **physician**, other **health professional**, **hospital**, **skilled nursing facility**, **home health care agency** or other entity or person licensed or certified under **applicable law** to provide health care services to **you**. If state law does not specifically provide for licensure or certification, the entity must meet all Medicare accreditation standards (even if it does not participate in Medicare).

Psychiatric Hospital

An institution specifically licensed or certified as a **psychiatric hospital** by **applicable law** to provide a program for the diagnosis, evaluation and treatment of alcoholism, drug abuse, **mental health disorders** (including **substance related disorders**) or mental **illnesses**.

Psychiatrist

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

R.N.

A registered nurse.

Referral

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

Residential Treatment Facility (Mental Health Disorders)

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

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

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

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

Residential Treatment Facility (Substance Related Disorders)

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

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

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

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

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

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

Retail Pharmacy

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

Room And Board

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

Semi-Private Room Rate

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

Service Area

The geographic area where **network providers** for this plan 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 Arizona 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.

Telephone calls are included when the use of an audio-only telephone encounter between an enrollee who has an existing relationship with a health care provider or provider group if both of the following apply:

- An audio-visual telehealth encounter is not reasonably available due to the enrollee's functional status, the enrollee's lack of technology or telecommunications infrastructure limits, as determined by the health care provider.
- The telehealth encounter is initiated at the request of the enrollee or authorized by the enrollee before the telehealth encounter.

Telemedicine

A health care service delivered by a **physician** licensed in the State of Arizona, or a **health professional** acting under the delegation and supervision of a **physician** licensed in the State of Arizona 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.

Telephone calls are included when the use of an audio-only telephone encounter between an enrollee who has an existing relationship with a health care provider or provider group if both of the following apply:

- An audio-visual telehealth encounter is not reasonably available due to the enrollee's functional status, the enrollee's lack of technology or telecommunications infrastructure limits, as determined by the health care provider.
- The telehealth encounter is initiated at the request of the enrollee or authorized by the enrollee before the telehealth encounter.

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**