

Imperial Insurance Companies, Inc.
PO Box 61300
Pasadena, CA 91116
1-866-899-8885
www.ImperialHealthPlan.com

HEALTH MAINTENANCE ORGANIZATION (HMO) EVIDENCE OF COVERAGE (EOC)

IMPORTANT NOTE:

This is not a policy of workers' compensation insurance. The employer does not become a subscriber to the workers' compensation system by purchasing this policy. If the employer is a non-subscriber, the employer loses those benefits which would otherwise accrue under workers' compensation laws. The employer must comply with workers' compensation law as it pertains to non-subscribers and the required notifications that must be filed and posted.

IMPORTANT NOTE:

This document may be delivered to you electronically, but you may opt out of receiving electronic communication at any time. You may opt out of receiving electronic communications at any time by calling Member Services at 1-866-899-8885.

IMPORTANT NOTE:

Your rights with a Health Maintenance Organization (HMO) plan
Notice from the Texas Department of Insurance

Your plan
Your HMO plan contracts with doctors, facilities, and other health care **providers** to treat its **members**. **Providers** that contract with **your** health plan are called "**contracted providers**" (also known as "**in-network providers**"). **Contracted providers** make up a plan's network. **Your** plan will only pay for health care **you** get from doctors and facilities in its network.

However, there are some exceptions, including for emergencies, when **you** didn't pick the doctor, and for ambulance services.

Your plan's network
Your health plan must have enough doctors and facilities within its network to provide every service the plan covers. **You** shouldn't have to travel too far or wait too long to get care. This is called "network adequacy." If **you** can't find the care you need, ask **your** health plan for help. **You** have the right to receive the care **you** need under **your** in-network benefit.

If **you** don't think the network is adequate, **you** can file a complaint with the Texas Department of Insurance at www.tdi.texas.gov or by calling 800-252-3439.

List of doctors
You can get a directory of health care **providers** that are in **your** plan's network.

You can get the directory online at www.ImperialHealthPlan.com or by calling the toll-free number on **your** ID card.

If **you** used **your** health plan's directory to pick an in-network health care **provider** and they turn out to be out-of-network, **you** might not have to pay the extra cost that **out-of-network providers** charge.

Bills for health care
If **you** got health care from a doctor that was out-of-network when **you** were at an in-network facility, and **you** didn't pick the doctor, **you** won't have to pay more than **your** regular **copayment**. Protections also apply if **you** got emergency care at an out-of-network facility or lab work or imaging in connection with in-network care.

If **you** get a bill for more than **you're** expecting, contact **your** health plan. Learn more about how you're protected from surprise medical bills at tdi.texas.gov.



This Evidence of Coverage (**EOC**) is by and between Imperial Insurance Companies, Inc. (Imperial, **we**, **us**, or **our**) and the subscriber (**you**, **your**).
Coverage starts on **your effective date of coverage** and continues until it ends as described in this **EOC**. **Your EOC** provides coverage for services and supplies that are **covered benefits**. It describes **your** coverage only. **You** may get health care services or **prescription drugs** that might not be **covered benefits** under **your EOC**. Please read **your EOC** and the Schedule of Benefits because they explain **your** benefits in detail.

This **EOC** is issued by Imperial Insurance Companies., a Texas corporation (Imperial) and is governed by federal law and the laws of Texas.

Read Your EOC Carefully

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

Guaranteed Renewable

You can renew this **EOC** each year ("guaranteed renewable"). **We** decide the **premium** rates. But, **we** may decide not to renew the **EOC** under certain conditions, which are explained in this **EOC**, or when required by law. See the *When Coverage Ends* section of the **EOC** for more information.
You may keep this **EOC** in effect by meeting the **EOC** requirements and by paying the **premium** on time. See the *What Does The **EOC** Cost **You**?* section of the **EOC** for more information.

Your Application

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

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

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



IMPERIAL INSURANCE COMPANIES

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.
Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

Imperial Insurance Companies, Inc.
To get information or file a complaint with your insurance company or HMO:
Call: Member Services at 1-866-899-8885
Toll-free: 1-866-899-8885
Online: www.ImperialHealthPlan.com
Mail: Imperial Insurance Companies, Inc., Attn: Appeal and Grievance Department, 1100 East Green Street, Pasadena, CA 91116

The Texas Department of Insurance
To get help with an insurance question or file a complaint with the state:
Call with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: Consumer Protection, MC: CO-CP, Texas Department of Insurance, P.O. Box 12030, Austin, TX 78711-2030

Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamacion o con su prima de seguro, llame prim ero a su compania de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nom bre en ingles) pueda ayudar.
Aun si usted presenta una queja ante el Departamento de Seguros de Texas, tam bien debe presentar una queja a traves del proceso de quejas ode apelaciones de su compania de seguros o HMO. Si no lo hace, podria perder su derecho para apelar.

Imperial Insurance Companies, Inc.
Para obtener informacion o para presentar una queja ante su compania de seguros o HMO:
Llame a: Member Services al 1-866-899-8885
Telefono gratuito: 1-866-899-8885
En linea: www.ImperialHealthPlan.com
Direccion postal: Imperial Insurance Companies, Inc., Attn: Appeal and Grievance Department, 1100 East Green Street, Pasadena, CA 91116

El Departamento de Seguros de Texas
Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:
Llame con sus preguntas al: 1-800-252-3439
Presente una queja en: www.tdi.texas.gov
Correo electronico: ConsumerProtection@tdi.texas.gov
Direccion postal: Consumer Protection, MC: CO-CP, Texas Department of Insurance, P.O. Box 12030, Austin, TX 78711-2030



IMPERIAL INSURANCE COMPANIES

Your rights with a Health Maintenance Organization (HMO) plan

Notice from the Texas Department of Insurance

Your plan

Your HMO plan contracts with doctors, facilities, and other health care providers to treat its members. Providers that contract with your health plan are called "contracted providers" (also known as "in-network providers"). Contracted providers make up a plan's network. Your plan will only pay for health care you get from doctors and facilities in its network.

However, there are some exceptions, including for emergencies, when you didn't pick the doctor, and for ambulance services.

Your plan's network

Your health plan must have enough doctors and facilities within its network to provide every service the plan covers. You shouldn't have to travel too far or wait too long to get care. This is called "network adequacy." If you can't find the care you need, ask your health plan for help. You have the right to receive the care you need under your in-network benefit.

If you don't think the network is adequate, you can file a complaint with the Texas Department of Insurance at www.tdi.texas.gov or by calling 800-252-3439.

List of doctors

You can get a directory of health care providers that are in your plan's network.

You can get the directory online at www.ImperialHealthPlan.com or by calling the number on the back of your card.

If you used your health plan's directory to pick an in-network health care provider and they turn out to be out-of-network, you might not have to pay the extra cost that out-of network providers charge.

Bills for health care

If you got health care from a doctor that was out-of-network when you were at an in network facility, and you didn't pick the doctor, you won't have to pay more than your regular copay, coinsurance, and deductible. Protections also apply if you got emergency care at an out-of-network facility or lab work or imaging in connection with in-network care. [Include if balance billing is permitted for ground ambulance services under applicable state and federal law: However, protections do not apply for ground ambulance services.]

If you get a bill for more than you're expecting, contact your health plan. Learn more

about how you're protected from surprise medical bills at tdi.texas.gov.

IMPERIAL INSURANCE COMPANIES

WELCOME

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

This **EOC** 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 EOC** covers only a certain number of visits.

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

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

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

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

Welcome to **Imperial Insurance Companies, Inc**.

IMPERIAL INSURANCE COMPANIES

Imperial Insurance Companies Inc. 1

Service Area Counties



June 2, 2026

Service Areas

2027 Service Area (Tarrant County)

105.92 miles

IMPERIAL INSURANCE COMPANIES

TABLE OF CONTENTS

	Section
INTRODUCTION TO YOUR PLAN	1
DEFINITIONS	2
WHAT DOES THE EOC COST YOU?	3
WHO THE EOC COVERS	4
MEDICAL NECESSITY, REFERRAL, AND PREAUTHORIZATION REQUIREMENTS	5
COVERAGES	6
GENERAL EXCLUSIONS	7
WHO PROVIDES THE CARE	8
WHAT WE PAY AND WHAT YOU PAY	9
WHEN YOU DISAGREE - CLAIM DECISIONS AND APPEAL PROCEDURES	10
COORDINATION OF BENEFITS (COB)	11
WHEN COVERAGE ENDS	12
GENERAL PROVISIONS – OTHER THINGS YOU SHOULD KNOW	13
SCHEDULE OF BENEFITS	Issued With **Your EOC**

SECTION 1 – INTRODUCTION TO YOUR PLAN

Here are some basics. Please see below on how **we** use defined terms. Then **we** explain how **your EOC** 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 **EOC** and the Schedule of Benefits. If **you** need assistance or more information, please reach out to **us**.

How We Use Defined Terms

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

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

What Is Your EOC? – Provides Covered Benefits

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

How Does Your EOC Work? – Starts And Stops Coverage

Coverage under the **EOC** has a start and an end. First, **you** complete the eligibility and application process. Then the **EOC** is issued. **Your** coverage starts on the subscriber's **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 subscriber's **effective date of coverage** if the subscriber enrolled them at that time. See the *Effective Date Of Coverage For **Your** Dependent* section for details.

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

Ending coverage under the **EOC** does not necessarily mean **you** lose coverage with **us**. See the *Special Coverage Options After **Your** Coverage Ends* section.

How Does Your EOC 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 **EOC**

will not always cover the services **you** want. Sometimes it does not cover health care services **your** doctor will want **you** to have.

What are **eligible health services**? They are health care services that meet these three requirements:

- They appear in the *Coverages* section.
- They are not listed in the *General Exclusions* section. (**We** will refer to this section as the *"Exclusions"* section in the rest of this **EOC**.)
- They are not beyond any limits in the Schedule of Benefits.

2. Providers

Our network of doctors, **hospitals,** and other health care **providers** is there to give **you** the care **you** need. **You** can find **network providers** and see important information about them most easily on **our** online **provider directory**.

Visit **our** website. See the *Have a complaint or need help?*section.

You choose a **primary care physician** (**we** call that doctor **your PCP**) to oversee **your** care. **Your PCP** will provide **your** routine care, and send **you** to other **providers** when **you** need specialized care.

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

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

3. Service area

Your EOC generally pays for **eligible health services** only within a specific geographic area, called a **service area**. The **service area** of this **EOC** includes Tarrant County. **You** must reside, live or work in Imperial's service area. There are some exceptions, such as for **emergency services** and urgent care. See the *Who Provides The Care* section in **your EOC**.

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.

IMPORTANT NOTE FOR DEPENDENTS UNDER A QUALIFIED MEDICAL OR DENTAL SUPPORT ORDER:
IF **YOU** ARE REQUIRED TO COVER A DEPENDENT WHO RESIDES OUTSIDE THE **SERVICE AREA** UNDER A QUALIFIED MEDICAL OR DENTAL SUPPORT ORDER, **WE** WILL PROVIDE **YOUR** DEPENDENT WITH COVERAGE THAT IS COMPARABLE HEALTH OR DENTAL COVERAGE TO THAT IS PROVIDED TO OTHER DEPENDENTS UNDER A SEPARATE **EOC**.

4. Paying for eligible health services– the general requirements

There are several general requirements for the **EOC** to pay any part of the expense for an **eligible health service**. They are:

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

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

5. Paying for eligible health services – the general requirements

There are several general requirements for the **EOC** to pay any part of the expense for an **eligible health service**. They are:

- The **eligible health service** is **medically necessary**
- **You** get the **eligible health service** from a **network provider**
- **You** or **your provider pre-certifies** the **eligible health service** when required

You will find details on **medical necessity** and **precertification** requirements in the *Medical Necessity And Precertification Requirements* section in **your EOC**. **You** will find the requirement to use a **network provider** and any exceptions in the *Who Provides The Care* section in **your EOC**.

6. Paying for eligible health services – sharing the expense

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

But sometimes **your EOC** will pay the entire expense; and sometimes **you** will. For more information see the *What **We** Pay And What **You** Pay* section, and see the Schedule of Benefits in **your EOC**.

Your copayments will not exceed 50% of the total cost of services provided or 200% of the total annual **premium** cost. If **your copayments** have exceeded 200% of the total annual **premium** cost, **you** must submit a detailed explanation of benefits (EOB) showing the dates and total amount of the **copayments** paid.

7. Disagreements

We understand that there may be disagreements regarding certain issues.

The **EOC** informs **you** on how **we** will work through **our** differences. And if **we** still disagree, an independent group of experts called an "independent review organization" or "IRO" for short, may sometimes make the final decision for **us**.

For more information see the *When **You** Disagree - Claim Decisions And Appeal Procedures* section in **your EOC**.

How Can You Contact Us For Help?

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

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

Your Member ID Card

Your member ID card informs doctors, **hospitals**, and other **providers** that **you** are covered by this agreement. Show **your** ID card each time **you** get health care from a **provider** to help them bill **us** correctly and help **us** better process their claims.

Remember, only **you** and **your** covered dependents can use **your** member ID card. If **you** misuse **your** card **we** may end **your** coverage.

To get **your** ID card, log in to **our** secure website. See the *Have a complaint or need help?*section. **You** can print **your** ID card.

Inform The Exchange Of Any Changes

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

- Primary address
- Phone number
- Marital status or domestic partnership changes
- Dependent status
- **You** or **your** covered dependent get health coverage through a job-based plan or a program like Medicare, Medicaid or the Children's Health Insurance Program (CHIP)

It is important that **you** inform the Exchange 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 in **your EOC** for information on special or limited enrollment periods.

SECTION 2 – 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 **EOC**. 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.

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 **EOC**.

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.

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 EOC**. The most up-to-date **directory** for **your EOC** appears on **our** website. See the *Have a complaint or need help?*section. When searching for **providers**:
- Make sure **you** are searching for **providers** that participate in **your** specific plan
- Remember, some **network providers** may only be considered **network providers** for certain Imperial plans
- Search under dental plans for network **dental providers**

Drug Guide
A list of **prescription drugs** and OTC drugs and devices established by **us** or an affiliate provides coverage, approves payment and encourages or offers incentives. It does not include all **prescription drugs** and OTC drugs and devices. This list can be reviewed and changed by **us** or an affiliate only upon renewal and with 60 days' notice to **you**. A copy of the **drug guide** is available at **your** request, or **you** can find it on **our** website. See the *Have a complaint or need help?*section.

Durable Medical Equipment (DME)
Equipment, and the accessories needed to operate it, that is:
- Made to withstand prolonged use

- Mainly used in the treatment of an **illness** or **injury**
- Suited for use in the home
- Not normally used by people who do not have an **illness** or **injury**
- Not for altering air quality or temperature
- Not for exercise or training

Effective Date Of Coverage

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

Eligible Health Services

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

Emergency Medical Condition

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

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

Emergency Services

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

Experimental Or Investigational

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

- There is not enough outcome data available from controlled clinical trials published in the peer-reviewed literature to validate its safety and effectiveness for the **illness** or **injury** involved.
- The needed approval by the FDA has not been given for marketing.
- A national medical or dental society or regulatory agency has stated in writing that it is **experimental or investigational** or suitable mainly for research purposes.
- It is the subject of a Phase I, Phase II or the experimental or research arm of a Phase III clinical trial. These terms have the meanings given by regulations and other official actions and publications of the FDA and Department of Health and Human Services.
- Written protocols or a written consent form used by a facility **provider** stating it is **experimental or investigational**.
- It is provided or performed in a special setting for research purposes.

Generic Prescription Drug

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

- Dosage
- Safety
- Strength
- Quality
- Performance

Group

Group means the employer or party that has entered into a Group Agreement with **us** under which **we** will provide for or arrange health services for eligible Members of the Group who enroll.

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** for **eligible health services** as listed in the Schedule of Benefits.

Medically Necessary, Medical Necessity

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

- In accordance with generally accepted standards of medical practice
- Clinically appropriate, in terms of type, frequency, extent, and duration, and considered effective for the patient's **illness**, **injury** or disease
- Not primarily for the convenience of the patient, **physician** or other health care **provider**

Generally accepted standards of medical practice means:

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

Mental Health Disorder

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

Morbid Obesity

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

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

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

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 **EOC**.

For **prescription drug** services from a **network pharmacy***:*
The amount **we** established for each **prescription drug** obtained from a **network pharmacy** under this **EOC**. 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 under price guarantees. These amounts may not change the **negotiated charge** under this **EOC**.

Network Provider

A **provider** listed in the **directory** for **your EOC**.

Network Pharmacy

A **retail**, **mail order** or **specialty pharmacy** that has contracted with **us**, an affiliate or a third-party vendor to provide outpatient **prescription drugs** to **you**.

Non-Preferred Drug

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

Out-Of-Network Provider

A **provider** who is not a **network provider** or a **network provider** that is seen without a **referral**.

Partial Hospitalization Treatment

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

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

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

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

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

Preauthorization, Preauthorize
A requirement that **you** or **your physician** contact **us** before **you** receive coverage for certain services. This may include a determination by **us** as to whether the service is **medically necessary** and eligible for coverage.

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

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

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

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

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

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

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

Prescription Drug Co-Payment
A Co-Payment that only applies to Prescription Drug coverage.

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 **EOC** 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 Texas and acting within the scope of the **health professional's** license, certification or entitlement to a patient at a different physical location than the **health professional** using telecommunications or information technology.

Telemedicine

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

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

Urgent Care Facility
A facility licensed as a freestanding medical facility by **applicable law** to treat an **urgent condition**.

Urgent Condition
An **illness** or **injury** that requires prompt medical attention but is not an **emergency medical condition**.

Walk-In Clinic
A health care facility that provides limited medical care on a scheduled and unscheduled basis. A **walk- in-clinic** may be located in, near, or within a:

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

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

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

SECTION 3 – WHAT DOES THE EOC COST YOU?

Premium Payment
This **EOC** requires **you** to make **premium** payments. **We** will not pay benefits under this **EOC** for services obtained after coverage ends if **premium** payments are not made by the end of the grace period. Any benefit payment denial is subject to **our** appeals procedure. See the *When **You** Disagree – Claim Decisions And Appeal Procedures* section of this **EOC**.

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

After **your** first **premium** payment is made, **premium** payments are due on the 1st or 15th of each month based on **your effective date of coverage**. Each **premium** payment is to be paid to **us** on or before the due date. **Your premium** becomes overdue after the last day of the **premium** period.

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

The **group** is liable for **premium** payments from the time **you** cease to be eligible for coverage until the end of the contract month in which the **group** notifies **us** that **you** are no longer covered by the **group** and are not eligible for coverage. The **group** is required to provide coverage for **you** until the end of the contract month in which the termination notice or other such notice, if any, permitted by applicable law or regulatory guidance, is received by **us**.

Grace Period

You have a grace period of 30 days after the due date for the payment of each **premium** due after the first **premium** payment. If **premiums** are not paid by the end of the grace period, **your** coverage will automatically terminate at the last date for which the premium was paid, or as of the date required by **applicable law**.

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

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

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

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

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

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

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

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

Reinstatement

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

Premium Agreement

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

Your premium rate is based on factors such as:

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

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

In the event of any changes in **premium** rates, payment of the **premium** by **you** means that **you** accept the **premium** changes.

Premium – changes in rates

Any rate change will not be applied more frequently than annually or as allowed by federal or state law or regulation.

We will advise **you** in writing of any change in premium rates 60 days before they take effect.

IMPERIAL INSURANCE COMPANIES

SECTION 4 – WHO THE EOC COVERS

The eligibility process and enrollment process are subject to any rules or other standards of the Exchange and/or the Federal Department of Health and Human Services.

You will find information in this section about:

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

Who Is Eligible

You are eligible as the subscriber when **you** are:

- A legal resident of Texas
- Age 19 or older
- Not enrolled in Medicare at the time of application
- Listed as the applicant on the application
- Approved by **us**
- Satisfy any probationary or waiting period requirements established by the **group**.

You must reside, live or work in Imperial's service area in order to be eligible for coverage. **You** are enrolled as the subscriber after **you** complete the eligibility and enrollment process, are approved by the Exchange and **we** have issued the **EOC** to **you**.

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

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

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

  The children must be under 26 years of age 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
  - A grandchild who is **your** dependent for federal tax purposes
  - Any children approved by the Exchange

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

- The adoption becomes final

You can enroll **your** dependent:

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

A dependent must reside in the state where the **EOC** was issued and be approved by **us** and the Exchange.

A dependent child over the age 26 may qualify for coverage if that child is incapable of self-sustaining employment due to mental retardation or physical disability, and chiefly dependent on the subscriber for support and maintenance. Imperial may require the subscriber to furnish proof of incapacity and dependency within 31 days of the child's attainment of the limiting age and subsequently as required, but not more frequently than annually for any child over the age of 26.

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**.

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

- **You** or **your** dependent have lost minimum essential coverage.
- **You** have added a dependent because of marriage, birth, adoption or foster care. See the *Adding New Dependents* section (below) for more information.
- **You** or **your** dependent's enrollment or non-enrollment in a plan through the Exchange was unintended, was by accident or a mistake, and is due to an error, false information or delay by the Exchange.
- **You** or **your** dependent have proven to the Exchange that its plan did not honor or maintain an important provision of its contract with **you** or that **you** meet other unusual circumstances.
- **You** did not enroll a dependent in this **EOC** before because the dependent had other coverage and now that other coverage has ended.
- A court orders **you** to cover a current spouse or domestic partner or a child on **your** health **EOC**.
- **You** or **your** dependent are newly eligible or not eligible for the **premium** tax credit or change in eligibility for cost share reduction, for Exchange coverage.
- **You** or **your** dependent are eligible for new plans because **you** have moved to a new permanent location.
- **You** or **your** dependent are the victim of domestic abuse or spousal abandonment.
- **You** or **your** dependent become a citizen, a national or lawfully present in the United States.
- **You** are an American Indian or Alaska Native as defined by the Indian Health Care Improvement Act. In this situation:
  - **You**, or **you** and **your** dependents, may enroll in a Qualified Health Plan (QHP) or change from one QHP to another.
  - **You** can do this one time per month.

- **You** or **your** dependent become eligible for State **premium** assistance under Medicaid or an S-CHIP plan for the payment of **your premium** contribution for coverage under this plan.
- **You** or **your** dependent lose **your** eligibility for enrollment in Medicaid or an S-CHIP plan.
- **You** lose coverage due to a change in marital status; in this case, **you** will be issued a policy which most nearly approximates the policy **you** had in effect prior to the change in marital status.
- Your COBRA coverage has ended

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

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

Adding New Dependents

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

- A spouse - If **you** marry, **you** can put **your** spouse on **your EOC**:
  - The Exchange must receive **your** completed enrollment information not more than 60 days after the date of **your** marriage
  - Coverage will be effective on the first day of the month following plan selection
- A domestic partner - If **you** enter a domestic partnership, **you** can enroll **your** domestic partner on **your EOC**:
  - The Exchange must receive **your** completed enrollment information not more than 60 days after the date **you** file a Declaration of Domestic Partnership
  - Coverage will be effective on the first day of the month following plan selection
- A newborn child - **Your** newborn child is covered on **your EOC** for the first 60 days after birth:
  - To keep **your** newborn covered, the Exchange must receive **your** completed enrollment information or **you** can call to notify **us**. **You** must provide the information within 60 days of birth
  - **You** must still enroll the child within 60 days of birth even when coverage does not require payment of an additional **premium** for the covered dependent
  - If **you** miss this deadline, **your** newborn will not have benefits after the first 60 days
- An adopted child – **You** may put an adopted child on **your EOC** when **you** become a party in a suit for adoption, the adoption is complete or the date the child is placed for adoption. "Placed for adoption" means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child:
  - The Exchange must receive **your** completed enrollment information within 60 days after **you** become a party in a suit for adoption, the date of the adoption or the date the child was

placed for adoption
  - Benefits for **your** adopted child will begin on the date of the adoption (or placement) or the first day of the month following adoption (or placement)
- A foster child – **You** may put a foster child on **your EOC** when the child is placed within **your** foster care. A foster child is a child whose care, comfort, education and upbringing is left to persons other than the natural parents:
  - The Exchange must receive **your** completed enrollment information within 60 days after the date the child is placed with **you**.
  - Benefits for **your** foster child will begin on the date **you** legally become a foster parent or the first day of the month following this event.
- A stepchild - **You** may put a child of **your** spouse or domestic partner on **your EOC**:
  - **You** must complete **your** enrollment information and send it to **us** within 60 days after the date of **your** marriage or Declaration of Domestic Partnership with **your** stepchild's parent
- Court order – **You** can put a child **you** are responsible for under a qualified medical or dental support order or court-order on **your EOC**:
  - **You** must complete **your** enrollment information and send it to the Exchange within 60 days after the date of the court order

Effective Date Of Coverage For Your Dependent

Your dependent's coverage will start on **your effective date of coverage**, if **you** enrolled the dependent at that time, otherwise:

- As shown above under the *Adding New Dependents* section
- No later than the first day of the following month if completed enrollment information is received by the 15th of the month
- No later than the first day of the second month if completed enrollment information is received between the 16th and the last day of the month
- In accordance with the effective date of a court order
- An appropriate date based on the circumstances of the special enrollment period

SECTION 5 – MEDICAL NECESSITY, REFERRAL, AND PREAUTHORIZATION REQUIREMENTS

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

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

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

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

Medically Necessary; Medical Necessity

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

The **medical necessity** requirements are in the *Definitions* section in **your EOC**, 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**. **You** will have to pay for services if **your PCP** fails to ask **us** for the **referral**. Refer to the *What **We** Pay and What **You** Pay* section in **your EOC**.

Preauthorization

You need pre-approval from **us** for some **eligible health services**. Pre-approval is also called preauthorization**.** Preauthorization is not required for preventive care services such as periodic health examinations for adults, immunizations for children, well-child care from birth, cancer screenings, eye and ear examinations for children through age 17, and immunizations for adults.

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

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

For **preauthorization** of outpatient **prescription drugs**, see *Coverages – Prescription Drugs/Medications – What Preauthorization Requirements Apply.* If **your physician** or **PCP** does not get a required

preauthorization, **we** will not pay the **provider** who gives **you** the care. **You** will not have to pay either if **your physician** or **PCP** fails to ask **us** for **preauthorization**. If **your physician** or **PCP** requests **preauthorization** and **we** refuse it, **you** can still get the care, but the **EOC** will not pay for it. **You** will find details on requirements in the *What **We** Pay And What **You** Pay* - Important note – *When **You** Pay All* section. **You** have the right to appeal this decision. See the *When **You** Disagree – Claim Decisions And Appeal Procedures* section in **your EOC**.

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

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

Please see the *When **You** Disagree - Claim Decisions And Appeal Procedures* section for more information on **your** appeals rights in these situations.

SECTION 6 – COVERAGES

The information in this section is the first step to understanding **your EOC's eligible health services**. If **you** have questions about this section, see the *Have a complaint or need help?*section in **your EOC**.

Your EOC 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 **EOC** exclusions in the *General Exclusions* section in **your EOC** 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.

2. Preventive Care And Wellness

This section describes the **eligible health services** and supplies available under **your EOC** when **you** are well.

IMPORTANT NOTES:
1. **You** will see references to the following recommendations and guidelines in this section:
    - Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
    - United States Preventive Services Task Force
    - Health Resources and Services Administration
    - American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents

When these recommendations and guidelines are updated, they will apply to this **EOC**. The updates will be effective on the first day of the year, one year after the updated recommendation or guideline is issued.

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 *Have a complaint or need help?* section in **your EOC**. This information can also be found at **Healthcare.gov.**

Routine Physical Exams

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

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

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.
- Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.
- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
  - Screening and counseling services on topics such as:
    - Interpersonal and domestic violence
    - Sexually transmitted infections
    - Human Immune Deficiency Virus (HIV) infections
  - 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 Texas law including the cost of a newborn screening test kit in the amount provided by the Department of State Health Services.
- Bone mass measurement for the detection of low bone mass and to determine risk of osteoporosis and fractures associated with osteoporosis, for qualified individuals.

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

NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise you of certain coverage or benefits provided by your contract with us.

Coverage of Tests for Detection of Human Papillomavirus, Ovarian Cancer, and Cervical Cancer

Coverage is provided for each woman enrolled in the plan who is 18 years of age or older for expenses incurred for an annual, medically recognized diagnostic examination for the early detection of ovarian and

cervical cancer. Coverage required under this section includes a CA 125 blood test and, at a minimum, a conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the FDA, alone or in combination with a test approved by the FDA for the detection of the human papillomavirus. If any person covered by this plan has questions concerning the above, please see the Have a complaint or need help? section of this EOC.

Preventive Care Immunizations

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

Immunizations for children from birth to age 18

Covered services may include:

- Diphtheria, tetanus, pertussis
- Haemophilus 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 EOC** 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 EOC** 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 (All forms of low-dose mammography, including digital mammography and breast tomosynthesis)
- Physical examinations for the detection of prostate cancer
- 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 state law

NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise you of certain coverage and/or benefits provided by your contract with **us**.

Examinations for Detection of Prostate Cancer

Benefits are provided for each covered male for an annual medically recognized diagnostic examination for the detection of prostate cancer. Benefits include:

(a) a physical examination for the detection of prostate cancer; and

(b) a prostate-specific antigen test for each covered male who is

(1) at least 50 years of age; or

(2) at least 40 years of age with a family history of prostate cancer or other prostate cancer risk factor.

Coverage for Tests for Detection of Colorectal Cancer

Benefits are provided, for each person enrolled in the plan who is 50 years of age or older and at normal risk for developing colon cancer, for expenses incurred in conducting a medically recognized screening examination for the detection of colorectal cancer. Benefits include the covered person's choice of:

(a) a fecal occult blood test performed annually and a flexible sigmoidoscopy performed every five years, or
(b) a colonoscopy performed every 10 years.

If any person covered by this plan has questions concerning the above, please see the Have a complaint or need help? section of this EOC.

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 physicians**, **PCPs**, OBs, GYNs, or OB/GYN.

Comprehensive Lactation Support And Counseling Services

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

Breast Feeding Durable Medical Equipment

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

Breast Pump

Eligible health services include:

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

Family Planning Services – 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
- Contraception services during a **stay** in a **hospital** or other facility for medical care
- Male contraceptive methods, sterilization procedures or devices

3. 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**

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

- Allergy testing and allergy injections
- Radiological supplies, services, and tests
- Immunizations that are not covered as preventive care

Physician Surgical Services
Eligible health services include the services of:

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

The following are not covered under this benefit:

- A **stay** in a **hospital**. See the *Coverages – Inpatient and Outpatient Hospital Services* section.
- A separate facility charge for **surgery** performed in a **physician's** office.
- Service of another **physician** for the administration of a local anesthetic.

4. 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 EOC** will cover the extra expense of a private room when appropriate because of **your** medical condition.
- Services of **physicians.**
- 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.
- Short-term rehabilitation therapy services in the acute hospital setting.
- 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**.
- Drugs, medications, biologicals.

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.
- Inpatient Prior Authorization reviews both the necessity for the admission and the need for continued stay in the Hospital.

Specialty Prescription Drugs

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

- Purchased by **your provider**
- Injected or infused by **your provider** in an outpatient setting such as:
  - A free-standing outpatient facility
  - The outpatient department of a **hospital**

  - A **physician's** office
  - A home care **provider** in **your** home
- Listed on **our specialty prescription drug** list as covered under this **EOC**

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

See the *Have a complaint or need help?*section in **your EOC** to:
- Access the list of **specialty prescription drugs**
- Determine if coverage for a **specialty prescription drug** is under the *Prescription Drugs/Medications* section or this section

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

5. 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 EOC** will pay only for **physician** services and not for a separate fee for facilities.

The following are not covered under this benefit:
- A **stay** in a **hospital**. A **hospital stay** is an inpatient **hospital** benefit. See the *Coverages – Inpatient and Outpatient Hospital Services* section in **your EOC**.
- 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:

- **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 *Short-Term Rehabilitation Services and Habilitation Therapy Services* sections and the Schedule of Benefits.

The following are not covered under this benefit:

- **Custodial care**
- Services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities)
- Transportation
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present

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.

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

6. Emergency Services

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

The types of services that are eligible for coverage include:

- A medical screening examination or other evaluation, required by state or federal law and provided to covered enrollees in a **hospital** emergency facility, free-standing emergency care facility or comparable facility, necessary to determine if an **emergency medical condition** exists.
- Treatment to stabilize **your** condition.
- Care in an emergency facility, free-standing emergency care facility or comparable facility after **you** become stable. But only if the treating **provider** asks **us** and **we** approve the service within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient. **We** will approve or deny the request within an hour after receiving the request.

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** and **we** determine that **you** are medically able to travel or to be transported to a **network provider** if **you** need more care.

If **you** get care from an **out-of-network provider** for an **emergency medical condition** or **urgent condition**, **we** will pay the **provider** at **our** usual and customary rate or at an agreed rate charge. **You** can contact Member Services at the toll-free number on **your** ID card if **you** receive a bill from the **out-of-network provider**. **We** will work with the **provider** so that all **you** pay is the appropriate network level **copayment**.

IMPORTANT NOTE:

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

Follow-up care must be provided by **your physician**, **PCP**. Follow-up care from a **physician** other than **your PCP**, like a **specialist**, may require a **referral**. See the *Medical Necessity, Referral And Preauthorization Requirements* section in **your EOC** 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** can also dial 911 or **your** local emergency response service for medical and **ambulance** assistance. If possible, call **your physician**, but only if a delay will not harm **your** health.

Non-Emergency Condition

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

The following is not covered under this benefit:

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

7. 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 reasonably available to provide services, **you** may access urgent care from an **urgent care facility** within the **service area**.

Urgent Condition Outside The Service Area

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

Non-urgent care

See the *Exclusions* section and the Schedule of Benefits for specific plan details.

The following is not covered under this benefit:

- Non-**urgent condition** care in an **urgent care facility** or at a non-**hospital** free-standing facility

8. 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 Texas law

NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise you of certain coverage and/or benefits provided by your contract with us.

Inpatient Stay following Birth of a Child

For each person covered for maternity/childbirth benefits, we will provide inpatient care for the mother and her newborn child in a health care facility for a minimum of:
(a) 48 hours following an uncomplicated vaginal delivery, and
(b) 96 hours following an uncomplicated delivery by cesarean section.

This benefit does not require a covered female who is eligible for maternity/childbirth benefits to (a) give birth in a hospital or other health care facility or (b) remain in a hospital or other health care facility for the minimum number of hours following birth of the child.

If a covered mother or her newborn child is discharged before the 48 or 96 hours has expired, we will provide coverage for postdelivery care. Postdelivery care includes parent education, assistance and training in breast-feeding and bottle-feeding and the performance of any necessary and appropriate clinical tests. Care will be provided by a physician, registered nurse or other appropriate licensed health care provider, and the mother will have the option of receiving the care at her home, the health care provider's office or a health care facility.

Since we provide in-home postdelivery care, we are not required to provide the minimum number of hours outlined above unless (a) the mother's or child's physician determines the inpatient care is medically necessary, or (b) the mother requests the inpatient stay.

Prohibitions. We may not (a) modify the terms of this coverage based on any covered person requesting less than the minimum coverage required; (b) offer the mother financial incentives or other compensation for waiver of the minimum number of hours required; (c) refuse to accept a physician's recommendation for a specified period of inpatient care made in consultation with the mother if the period recommended by the physician does not exceed guidelines for prenatal care developed by nationally recognized professional associations of obstetricians and gynecologists or pediatricians; (d) reduce payments or reimbursements below the usual and customary rate; or (f) penalize a physician for recommending inpatient care for the mother and/or the newborn child.

If any person covered by this plan has questions concerning the above, please see the Have a complaint or need help? section of this EOC.

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**.

9. 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 *Have a complaint or need help?*section.

Eligible Health Services include:

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

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

Pediatric Vision Care Exclusions
The following are not covered under this benefit:

- Special supplies such as non-**prescription** sunglasses
- Non-**prescription** eyeglass frames, non-**prescription** lenses and non-**prescription** contact lenses
- Special vision procedures, such as orthoptics or vision therapy
- Eye exams during **your stay** in a **hospital** or other facility for health care
- Eye exams for contact lenses or their fitting
- Acuity tests
- Eye **surgery** for the correction of vision, including radial keratotomy, LASIK and similar procedures
- Services to treat errors of refraction

Pediatric Dental Care

Eligible health services include dental services and supplies provided by a **dental provider** for children, to

age 19, only. It also includes coverage health care services or procedures delivered by a preferred or contracted **health professional** as a **teledentistry** service. The **eligible health services** are those listed in the *Pediatric Dental Care* section of the Schedule of Benefits.

We will pay or otherwise discharge the 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 EOC 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.**

10. 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
- Other outpatient diagnostic imaging service where the billed charge exceeds $500

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 lab.

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

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

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

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 a laboratory that is certified by a recognized national organization:

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

Tests are available to each covered individual who is (1) a male older than 45 years of age and younger than 76 years of age, or (2) a female older than 55 years of age and younger than 76 years of age. The individual must be a diabetic or have a risk of developing coronary heart disease, based on a score derived using the Framingham Heart Study coronary prediction algorithm that is intermediate or higher.

Diagnostic Follow-Up Care Related To Newborn Hearing Screening

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

Outpatient Therapies

Chemotherapy

Eligible health services for chemotherapy depend on where treatment is received. In most cases, chemotherapy is covered as outpatient care. However, **your hospital** benefit covers the initial dose of chemotherapy after a cancer diagnosis during a **hospital stay**.

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 *Have a complaint or need help?*section in **your EOC** 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 *Have a complaint or need help?*section in **your EOC** 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, restore, maintain, or slow deterioration of 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.
  -

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. Treatment goals for a physical disability may include maintenance of functioning or prevention of or slowing of further deterioration.

Inpatient And Outpatient Treatment For Acquired Brain Injury

Eligible health services include treatment of an Acquired Brain Injury will be determined on the same basis as treatment for any other physical condition. Cognitive Rehabilitation Therapy, Cognitive Communication Therapy, Neurocognitive Therapy and Rehabilitation; Neurobehavioral, Neuropsychological, Neurophysiological and Psychophysiological Testing and Treatment; Neurofeedback Therapy, Remediation,

Post-Acute Transition Services and Community Reintegration Services, including Outpatient Day Treatment Services, or any other Post-Acute Treatment Services are covered, if such services are necessary as a result of and related to an Acquired Brain Injury.

Treatment for an Acquired Brain Injury may be provided at a hospital, an acute or post-acute rehabilitation hospital, an assisted living facility or any other facility at which appropriate services or therapies may be provided.

Service means the work of testing, treatment, and providing therapies to an individual with an Acquired Brain Injury.

Therapy means the scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an Acquired Brain Injury.

To ensure that appropriate post-acute care treatment is provided, this Plan includes coverage for reasonable expenses related to periodic reevaluation of the care of an individual covered who:

- has incurred an Acquired Brain Injury;
- has been unresponsive to treatment; and
- becomes responsive to treatment at a later date.

Treatment goals for services may include the maintenance of functioning or the prevention of or slowing of further deterioration.

Chiropractic

Eligible health services include chiropractic 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 if 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.

11. 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 EOC 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

IMPORTANT NOTE:

- Out-of-network providers do not have a contract with us. **We** will pay the provider at **our** usual and customary rate or at an agreed rate charge. The provider may not accept payment of **your** cost share (copayment), as payment in full. **You** may receive a bill for the difference between the amount billed by the provider and the amount paid by this plan. If the provider bills **you** for an amount above **your** cost share, **you** are not responsible for paying that amount.

The following are not covered under this benefit:

- **Ambulance** services for routine transportation to receive outpatient or inpatient services

If air **ambulance** services are received from an **out-of-network provider** that would otherwise be covered if received from an **in-network provider**, such services (i) shall be covered at the same cost sharing as would be applied if the service was provided by **an in-network provider** (and such cost sharing shall be determined

based upon **in-network** rates), and (ii) the cost sharing applied to such services shall be counted towards the **maximum out-of-pocket limit** applicable under **your EOC.**

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 a Texas 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 EOC** 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 **you** need it for long-term use.

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.

Your EOC only covers the same type of **DME** that Medicare covers. But there are some **DME** items Medicare covers that **your EOC** does not.

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* section
- Vision aids
- Telephone alert systems

Hearing Aids

Eligible health services include prescribed hearing aids and hearing aid services as described below. **We** will not deny a claim for a hearing aid solely on the basis that the price of the hearing aid is more than the benefits available under this service. Please see your Schedule of Benefits for cost sharing information.

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 **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

The following are not covered under this benefit:

- A replacement of:
  - A hearing aid that is lost, stolen or broken
  - A hearing aid installed within the prior 36-month period
- Replacement parts or repairs for a hearing aid
- Batteries or cords
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss
- Hearing exams given during a **stay** in a **hospital** or other facility, except those provided to newborns as part of the overall **hospital stay**.
- Any tests, appliances and devices to:
  - Improve **your** hearing, including hearing aid batteries and auxiliary equipment
  - Enhance other forms of communication to make up for hearing loss or devices that simulate speech

Hearing Aids And Cochlear Implants And Related Services

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

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

The following are not covered under this benefit:

- 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. **We** will cover these items to the same extent that the plan covers drugs that are available only on the orders of a physician.

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

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

Orthotic devices

Eligible health services include the initial orthotic device and subsequent replacement 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 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

- Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of, or to prevent complications of, diabetes or if the orthopedic shoe is an integral part of a covered leg brace
- 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
  - Test strips for blood glucose monitors
  - Visual reading and urine test strips
  - Lancets and lancet devices
  - Insulin and insulin analogs
  - Injection aids
  - Syringes
  - Prescriptive and nonprescriptive oral agents for controlling blood sugar levels
  - Glucagon emergency kits
- Equipment
  - Blood glucose monitors, including noninvasive glucose monitors and glucose monitors designed to be used by blind individuals
  - Insulin pumps and associated appurtenances
  - Insulin infusion devices
  - Podiatric appliances for the prevention of complications associated with diabetes
- Education
  - Self-management training provided by a health care **provider** certified in diabetes self-management training

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

Coverage for new or improved diabetes equipment or supplies, including improved insulin or another **prescription drug**, approved by the United States Food and Drug Administration, is provided, if the equipment or supplies are determined by **your physician** or other health care practitioner to be **medically necessary** and appropriate.

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)

The following are not covered under this benefit:

- Non-surgical treatment of **jaw joint disorder**

Behavioral Health

Mental health treatment

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

- **Inpatient room and board** at the **semi-private room rate** (the **EOC** 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:
      - **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. The peer support specialist must be certified by the state where the services are provided or a private certifying organization recognized by **us**. 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 **EOC** 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. The peer support specialist must be certified by the state where the services are provided or a private certifying organization recognized by **us**. 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 quantitative or nonquantitative treatment limitations on benefits for mental **health disorders** or **substance related disorders** that are generally more restrictive than quantitative, or

nonquantitative 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.
    - Unless **you** or **your physician** decide that a shorter time period for inpatient care is appropriate, **covered services** for reconstructive breast **surgery** include:
        - 48 hours of inpatient care following a mastectomy
        - 24 hours of inpatient care in a network health care facility after lymph node dissection for treatment of breast cancer
- **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, except as a result of chewing or biting, 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.

NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise you of certain coverage and/or benefits provided by your contract with us.

Mastectomy or Lymph Node Dissection

Minimum Inpatient Stay: If due to treatment of breast cancer, any person covered by this plan has either a mastectomy or a lymph node dissection, this plan will provide coverage for inpatient care for a minimum of:

(a) 48 hours following a mastectomy, and

(b) 24 hours following a lymph node dissection.

The minimum number of inpatient hours is not required if the covered person receiving the treatment and the attending physician determine that a shorter period of inpatient care is appropriate. Prohibitions: We may not

(a) deny any covered person eligibility or continued eligibility or fail to renew this plan solely to avoid providing the minimum inpatient hours; (b) provide money payments or rebates to encourage any covered person to accept less than the minimum inpatient hours; (c) reduce or limit the amount paid to the attending physician, or otherwise penalize the physician, because the physician required a covered person to receive the minimum inpatient hours; or (d) provide financial or other incentives to the attending physician to encourage the physician to provide care that is less than the minimum hours.

Coverage and/or Benefits for Reconstructive Surgery After Mastectomy-Annual
Your contract, as required by the federal Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If any person covered by this plan has questions concerning the above, please see the Have a complaint or need help? section of this EOC.

Transplant Services

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

This includes the following transplant types:

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

Network Of Transplant Facilities
We designate facilities to provide specific services or procedures. They are listed as Imperial Value facilities in **your** provider directory.

You must get transplant services from the Imperial Value facility **we** designate to perform the transplant **you** need. Transplant services received from the Imperial Value facility are subject to the network **copayment** and maximum out of pocket limits, unless stated differently in this **EOC** and Schedule of Benefits.

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 or tissue (xenograft) obtained from another species
- If the transplant operation is performed in China or another country known to have participated in forced organ harvesting
- The human organ to be transplanted was procured by a sale or donation originating in China or another country known to have participated in forced organ harvesting

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:

- All charges associated with:
  - Surrogacy for **you** or the surrogate. A surrogate is a female carrying her own genetically related child where the child is conceived with the intention of turning the child over to be raised by others, including the biological father.
  - 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).
- To do **surgery** to treat the underlying medical cause of **infertility**. An examples is varicocele surgery.

12. 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 EOC**
- 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 formulary exception request

- Prescribing units

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

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

Your EOC 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.

How To Access Network Pharmacies

How To Find A Network Pharmacy

You can find a **network pharmacy** online or by phone. See the *Have a complaint or need help?* section for details.

You may go to any of **our network pharmacies**. If **you** do not get **your prescriptions** at a **network pharmacy**, **your prescriptions** will not be covered as **eligible health services** under the **EOC**. **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 EOC

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

- They are listed in the *Coverages* section
- They are not listed in the *Exclusions* section
- They are not beyond any limits in the Schedule of Benefits

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

- **You** need a **prescription** from **your prescriber**.
- **Your** drug needs to be **medically necessary**. See the *Medical Necessity Referral And Preauthorization Requirements* section.
- **You** need to show **your** ID card to the **pharmacy** when **you** get a **prescription** filled.

We base **your prescription** drug plan on drugs listed in the **drug guide**. **We** exclude **prescription** drugs not in the **drug guide** unless **we** approve a formulary 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 formulary exception. See the *Requesting A Formulary Exception* section 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 90-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 *Have a complaint or need help?*section in **your EOC** 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.

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 EOC, we will allow the dollar value of the coupon, or other offer to reduce any applicable, **maximum out-of-pocket limit** or **copayment**.

Except as stated above, if You redeem a coupon or other offer from a pharmaceutical manufacturer for a Prescription Drug or Related Supply covered under this EOC, we may not allow the dollar value of the coupon, or other offer to reduce any applicable **maximum out-of-pocket limit** or **copayment**.

If **you** have been diagnosed with a chronic, complex, rare, or life-threatening medical condition, clinician-administered drugs may be administered under the Prescription Drugs/Medication benefit as a **specialty prescription drug** with:

- **Your** written consent
- A written attestation by a physician or health care provider that a delay in the drug's administration will not place the patient at an increased health risk; and
- A determination by a physician or health care provider determines that a delay of care would make disease progression probable; or the use of a **pharmacy** within the health benefit plan issuer's network would:
  - make death or patient harm probable
  - potentially cause a barrier to the patient's adherence to or compliance with the patient's plan of care; or
  - because of the timeliness of the delivery or dosage requirements, necessitate delivery by a different **pharmacy**

In the case that **we** administer a clinician-administered drug under the Prescription Drugs/Medication benefit, **we** will not require the **prescription drug** to be dispensed by certain pharmacies. All cost sharing and supply limits are equivalent to that of in-network **specialty prescription drugs** as listed in the Schedule of Benefits, regardless of which **pharmacy** is able to administer the clinician-administered **prescription**.

Other Services

Preventive Contraceptives

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. See the *Have a complaint or need help?*section for how.

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.

A **prescription** for a covered contraceptive drug will be allowed as follows:

- A 3-month supply the first time the contraceptive is obtained; and
- A 12-month supply for each subsequent time the contraceptive drug is obtained
  - Members can only obtain one 12-month supply of the drug during each 12-month period

Diabetic Supplies

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

- Test strips for blood glucose monitors
- Visual reading and urine test strips
- Lancets and lancet devices
- Insulin and insulin analogs
- Injection aids
- Syringes
- Prescriptive and nonprescriptive oral agents for controlling blood sugar levels
- Glucagon emergency kits

See the *Coverages – Other Services and Conditions - Diabetic Equipment, Supplies And Education* section in **your EOC** 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 in a manner that limits disruption in care, including limiting the number of biopsies and biospecimen samples for the purposes of diagnosis, treatment, appropriate management or ongoing monitoring of a disease or condition to guide treatment

decisions when the test provides **clinical utility** as demonstrated by medical and scientific evidence, including any of the following:

- Labeled indications for tests that are approved or cleared by the United States Food and Drug Administration or indicated tests for a drug that is approved by the Unites 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**

Fertility Preservation

This EOC provides benefits for fertility preservation services to members who will receive medically necessary treatment for cancer. Treatment for cancer includes surgery, chemotherapy, or radiation that the American Society of Clinical Oncology or the American Society for Reproductive Medicine has established may cause impaired fertility. Fertility preservation services must be standard procedures consistent with established medical practices or guidelines published by the entities listed above. The following services are included:

- collection of sperm;
- cryo-preservation of sperm;
- oocyte cryo-preservation;
- ovarian tissue cryo-preservation

Storage of such unfertilized genetic materials are not covered.

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. **We** will cover these items to the same extent that the plan covers drugs that are available only on the orders of a physician.

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

Orally Administered Anti-Cancer Drugs, Including Chemotherapy Drugs

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

Prescription Eye Drops

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

- The original **prescription** states that additional quantities are needed

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

Preventive Care Drugs And Supplements

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

Risk Reducing Breast Cancer Prescription Drugs

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

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

Tobacco Cessation Prescription And Over-The-Counter Drugs

Eligible health services include FDA approved **prescription drugs** and over-the-counter (OTC) drugs to help stop the use of tobacco products, when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing.

The following are not covered under this benefit:

- Abortion drugs
- Allergy serum and extracts administered by injection
- Any services related to the dispensing, injection or application of a drug
- Biological liquids and fluids unless specified on the **drug guide**
- **Cosmetic** drugs
  - Medications or preparations used for **cosmetic** purposes
- Compound **prescriptions** containing bulk chemicals that have not been approved by the FDA, including compounded bioidentical hormones
- Devices, products and appliances, except those that are specifically covered
- Dietary supplements including medical foods
- Drugs or medications:
  - Administered or entirely consumed at the time and place it is prescribed or dispensed
  - 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
  - Provided under **your** medical benefits while an inpatient of a healthcare facility
  - Recently approved by the FDA, but which have not yet been reviewed by **our** Pharmacy and Therapeutics Committee
  - That includes vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
  - For which the cost is covered by a federal, state or government agency (for example:

Medicaid or Veterans Administration)
  - Not approved by the FDA or not proven to be safe and effective
  - That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature unless there is evidence that the member meets one or more clinical criteria detailed in **our preauthorization** and clinical policies
- Duplicative drug therapy (e.g. two antihistamine drugs)
- Genetic care
  - Any treatment, device, drug, service or supply to alter the body's genes, genetic make-up or the expression of the body's genes except for the correction of congenital birth defects
- Immunizations related to travel or work
- Immunization or immunological agents except as specifically provided in the *Coverages – Prescription Drugs/Medications* section
- Implantable drugs and associated devices except where stated above
- **Infertility**
  - **Prescription drugs** used primarily for the treatment of **infertility** except where stated in the *Coverages – Other Services and Conditions – Treatment Of Infertility* section
- Injectables:
  - Any charges for the administration or injection of **prescription drugs** or injectable insulin and other injectable drugs covered by **us**.
  - Needles and syringes, except those used for insulin administration.
  - For any drug, which due to its characteristics, as determined by **us**, must typically be administered or supervised by a qualified **provider** or licensed certified **health professional** in an outpatient setting. This exception does not apply to Depo Provera and other injectable drugs used for contraception.
- Off-label drug use except for indications recognized through peer-reviewed medical literature or a prescription drug reference compendium approved by the commissioner
- **Prescription Drugs**:
  - That are ordered by a **dentist** or prescribed by an oral surgeon in relation to the removal of teeth, or **prescription drugs** for the treatment of a dental condition unless dental benefits are provided under **your EOC**.
  - That are considered oral dental preparations and fluoride rinses, except pediatric fluoride tablets or drops as specified on the **drug guide**.
  - That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance or drugs obtained for use by anyone other than the member identified on the ID card.
- Replacement of lost or stolen **prescriptions**
- Tobacco cessation drug unless recommended by the United States Preventive Services Task Force (USPSTF). See the *Coverages – Prescription Drugs/Medications - Tobacco Cessation Prescription And Over-The-Counter Drugs* section.
- Test agents except diabetic test agents
- A manufacturer's product when the same or similar drug (one with the same active ingredient or same therapeutic effect), supply or equipment is on the plan's **drug guide**
- Any dosage or form of a drug when the same drug is available in a different dosage or form on the plan's **drug guide**

How You Get An Emergency Prescription Filled

You may not have access to a **network pharmacy** in an emergency or urgent care situation, or **you** may be traveling outside of the **EOC**'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 **EOC**.

Your prescription drug costs are based on:

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

The **EOC** may, in certain circumstances, make some **preferred brand-name prescription drugs** available to members at the generic **copayment** level. Your prescription copayment shall be no greater than the cost of the drug if you were to pay for it without using the benefits of this EOC.

What Preauthorization Requirements Apply

Why Some Drugs Need Preauthorization

For certain drugs, **you**, **your prescriber** or **your** pharmacist needs to get approval from **us** before **we** will cover the drug. This is called "**preauthorization.**" The requirement for getting approval in advance guides appropriate use of preauthorized drugs and makes sure they are **medically necessary**. For the most up-to-date information, call **us** or go online. See the *How To Contact **Us** For Help* section in **your EOC** for details. Compliant with applicable Texas law, **we** will not require an enrollee to receive more than one **preauthorization** annually for certain **prescription drugs** prescribed to treat an autoimmune disease, hemophilia, or Von Willebrand disease. For a list of drugs that are excluded from this law, please contact **us**.

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 *Have a complaint or need help?*section in **your EOC** for details.

For treatment of serious mental **illness** for members 18 years or older, for covered **prescription drugs** approved by the FDA will not require that the member:

- fail to successfully respond to more than one different drug for each drug prescribed, excluding the generic or pharmaceutical equivalent of the prescribed drug; or
- prove a history of failure of more than one different drug for each drug prescribed, excluding the generic or pharmaceutical equivalent of the prescribed.

Step Therapy may be required for a trial of a generic or pharmaceutical equivalent of a prescribed **prescription drug** as a condition of continued coverage of the prescribed drug only:

- once in a plan year; and
- if the generic or equivalent drug is added to the plan's Drug List.

How To Request A Formulary Exception Request

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

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

You, someone who represents **you**, or **your provider** may seek a quicker **prescription drug** 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.

Prescribing units

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

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

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

SECTION 7 – GENERAL EXCLUSIONS

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

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

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 EOC** except as described in the *Coverages* section of this **EOC** or by a rider or amendment included with this **EOC**:

Acupuncture
Your EOC does not cover services for acupuncture.

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

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

Blood, Blood Plasma, Synthetic Blood, Blood Derivatives Or Substitutes, (Except As Described In The *Coverages – Inpatient and Outpatient Hospital Services – Hospital Care* Section
Examples of these are:

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

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

Clinical Trial Therapies (Experimental Or Investigational)

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

Cosmetic Services And Plastic Surgery

- Any treatment, **surgery** (**cosmetic** or plastic), service or supply to alter, improve or enhance the shape or appearance of the body, except where described in the *Coverages* section

Court-Ordered Testing

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

Custodial Care

Examples are:

- Routine patient care such as changing dressings, periodic turning and positioning in bed.
- Administering oral medications.
- Care of a stable tracheostomy (including intermittent suctioning).
- Care of a stable colostomy/ileostomy.
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or 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 the *When **You** Disagree - Claim Decisions And Appeal Procedures* section for more information on **your** appeals rights in these situations.

Facility Charges

For care, services or supplies provided in:

- Rest homes
- Assisted living facilities
- Similar institutions serving as a person's main residence or providing mainly custodial or rest care
- Health resorts
- Spas or sanitariums
- Infirmaries at schools, colleges, or camps

Foot Care

- Services and supplies for:
  - The treatment of calluses, bunions, toenails, hammertoes, fallen arches
  - The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes
    - Supplies (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies, except for complications of diabetes. See the *Other Services and Conditions* section.

Gene-Based Therapies (GBT)

Gene-Based Therapies are not **eligible health services** unless **you** receive prior written approval from **us.**

Growth/Height care

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

Jaw Joint Disorder

- **Jaw joint disorder** treatment performed by prosthesis placed directly on the teeth, surgical and non-surgical medical and dental services, and diagnostic or therapeutic services related to **jaw joint disorder**

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
  - Elastic garments
  - 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

Obesity (Bariatric) Surgery And Weight Management

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

Orthotic Devices

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

Other Primary Payer

- Payment for a portion of the charge that Medicare is responsible for as the primary payer. This exclusion does not apply to laws that make the government program the secondary payer after benefits under this EOCC have been paid.

Personal Care, Comfort Or Convenience Items

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

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

Services Provided By A Family Member

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

Services, Supplies And Drugs Received Outside Of The United States

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

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 when **you** are not present at the same time as the **provider**
- Services including:
  - Telephone calls
  - **Telemedicine** or **telehealth** kiosks
  - Electronic vital signs monitoring or exchanges (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 **EOC**:

- Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including medications, nicotine patches and gum unless recommended by the United States Preventive Services Task Force (USPSTF). This also includes:

- Counseling, except where stated in the *Coverages – Preventive Care And Wellness* section
- Hypnosis and other therapies
- Medications, except where stated in the *Coverages – Prescription Drugs/Medications* section
- Nicotine patches
- Gum

Treatment In A Federal, State, Or Governmental Entity

Except where required by **applicable law**:

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

Wilderness treatment programs

- See *Educational Services* in this section.

Work Related Illness Or Injuries

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

SECTION 8 – WHO PROVIDES THE CARE

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

For **you** to receive the benefits, **you** must use **network providers** for **eligible health services**. There are some exceptions:

- **Emergency services** – refer to the description of **emergency services** and urgent care in the *Coverages* section.
- Urgent care – refer to the description of **emergency services** and urgent care in the *Coverages* section and to the Schedule of Benefits.
- **Network provider not reasonably available** – **You** can get **eligible health services** under **your EOC** 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 *Have a complaint or need help?* section for assistance. **We** will make a decision as soon as **your** medical condition requires but no later than 5 working days after **we** receive all of the information **we** need from **your provider**. **We** may decide not to approve **your** request. Before **we** deny the request, a **specialist** of the same or similar specialty as the **provider you** are requesting to see will review **your** request. If access is approved, **we** will pay the **out-of-network provider** at **our** usual and 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 *Have a complaint or need help?* section for assistance.
- Transplants – see the description of transplant services in the *Coverages* section

You may select a **network provider** from the **directory** through **our** website. See the *Have a complaint or need help?* section. **You** can search **our** online **directory** for names and locations of **providers**.

You will not have to submit claims for treatment received from **network providers**. **Your network provider** will take care of that for **you**. **We** will directly pay the **network provider** for what the **EOC** owes.

Your PCP

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

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

- 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 *When **You** Disagree - Claim Decisions And Appeal Procedures* section.

How To Choose Your PCP

You can choose a **PCP** from the list of **PCPs** in **our 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** may receive treatment for up to 15 consecutive business days from certain physical therapists without a **referral**. Please contact **your** physical therapist for additional information**.**

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

How To Change Your PCP

You may change **your PCP** at any time. **You** can call **us** at the number on **your** ID card or log in to **our** website. See the *Have a complaint or need help?*section to make a change.

What Happens If You Do Not Select A PCP

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

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

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

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

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

	If You Are A New Enrollee And Your Provider Is An Out-Of-Network Provider	**When Your Provider Stops Participation With Us**
Request for approval	**You** need to complete a Transition of Coverage Request form and send it to **us**. **You** can get this form by calling the number on **your** ID card.	**You** or **your provider** should call **us** for approval to continue any care.
Length of transitional period	Care will continue during a transitional period, usually 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 9 – 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 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**:

- Imperial and **you** share the expense up to any **maximum out-of-pocket limit**. **Your** share is called a **copayment**.
- Then, **We** pay the entire expense after **you** reach **your maximum out-of-pocket limit**.

When **we** say "expense" in this general rule, **we** mean **negotiated charge** for a **network provider**. See the *Definitions* section for what this term means.

Important Note – When We Pay All

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

Important Note – When You Pay All

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

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

IMPORTANT NOTE:

Although health care services may be or have been provided to **you** at a health care facility that is a member of the provider network used by **your** health benefit plan, other professional services may be or have been provided at or through the facility by physicians and other health care practitioners who are not members of that network. **You** may be responsible for payment of part of the fees for those professional services that are not paid or covered by **your** health benefit plan. Please contact **us** immediately if **you** are in receipt of a balance bill for covered services from any physician or **provider**, including a facility-based physician or other health care practitioner.

Special Financial Responsibility

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

Neither **you** nor **we** are responsible for charges, expenses or costs in excess of the **negotiated charge** for **covered benefits**.

Where Your Schedule Of Benefits Fits In

The Schedule of Benefits shows any benefit limitations that apply to **your EOC**. 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 including any applicable **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 **EOC**.

SECTION 10 – WHEN YOU DISAGREE - CLAIM DECISIONS AND APPEAL PROCEDURES

In the previous section, **we** explained how **you** and **we** share responsibility for paying for **your eligible health services**.

When a claim comes in, **we** review it, make a decision and tell **you** how **you** and **we** will split the expense. **We** also explain what **you** can do if **you** think the decision was incorrect.

Claim Procedures

For claims involving **out-of-network providers**:

Notice	Requirement	Deadline
Submit a claim	• **You** should notify and request a claim form from **us**. • The claim form will provide instructions on how to complete and where to send the forms.	• Within 15 working days of **your** request. • If the claim form is not submitted on time, **we** will accept a written description that is the basis of the claim as proof of loss. It must detail the nature and extent of loss within 90 days of **your** loss.
Proof of loss (a claim) When **you** have received a service from an eligible **provider**, **you** will be charged. The information **you** receive for that service is **your** proof of loss.	• A completed claim form and any additional information required by **us**.	• **You** or **your provider** must submit notice and proof within 12 months of the date **you** received services, unless **you** are legally unable to notify **us**. • **We** will not void or reduce **your** claim if **you** cannot submit send **us** notice and proof of loss within the required time. But **you** must submit notice and proof as soon as reasonably possible. • Proof of loss may not be given later than 1 year after the time proof is otherwise required, except if **you** are legally unable to notify **us**.

Notice	Requirement	Deadline
Benefit payment	• Written proof must be provided for all benefits.	• **We** will notify **you** of **our** decision within 15 days of receipt of all necessary documentation. • If any portion of a claim is contested by **us**, the uncontested portion of the claim will be paid no later than the 5th business day after the above notice is made.

Types Of Claims And Communicating Our Claim Decisions

Your Network Provider will send **us** a claim on **your** behalf. **We** will review that claim for payment to the **provider.**

There are different types of claims. The amount of time that **we** have to tell **you** about **our** decision on a claim depends on the type of claim. The section below will tell **you** about the different types of claims.

Urgent Care Claim

An urgent claim is one for which the doctor treating **you** decides a delay in getting medical care could put **your** life or health at risk, a delay might put **your** ability to regain maximum function at risk. Or it could be a situation in which **you** need care to avoid severe pain.

If **you** are pregnant, an urgent claim also includes a situation that can cause serious risk to the health of **your** unborn baby.

Pre-Service Claim

A pre-service claim is a claim that involves services **you** have not yet received and which **we** will pay for only if **we preauthorize** them.

Post-Service Claim

A post service claim is a claim that involves health care services **you** have already received.

Concurrent Care Claim Extension

A concurrent care claim extension happens when **you** ask **us** to approve more services than **we** have already approved. Examples are extending a **hospital stay** or adding a number of visits to a **provider**.

Concurrent Care Claim Extension Decision

You or **your provider** may ask for a concurrent care claim extension to request more services. **We** will tell **you** when **we** make the decision. If **we** make an adverse determination, **you** will have enough time to file an appeal. **Your** coverage for the service or supply will continue until **you** receive a final appeal decision from **us** or an independent review organization, if the situation is eligible for independent review.

During this concurrent care claim extension period, **you** are still responsible for **your** share of the costs, such as **copayments** that apply to the service or supply. If **your** request for extended services is not approved after **your** adverse determination appeal, and **we** support **our** decision to reduce or terminate such services, **you** will be responsible for all of the expenses for the service or supply received during the concurrent care claim extension period.

Preauthorized Health Care Services and Treatment

The chart below shows the different types of health care services and treatment, **we** preauthorize and how much time **we** have to tell **you** about **our** decision.

We may need to tell **your physician** about **our** decision on some types of claims, such as a concurrent care claim, or a claim when **you** are already receiving the health care services or are in the **hospital**.

Type Of Notice	**Initial Determination (Us)**	**Extensions**	**Additional Information Request (Us)**	**Response To Additional Information Request (You)**
Pre-Service Claim*	No later than 3 calendar days after **we** receive the request	Not applicable	Not applicable	Not applicable
Concurrent Care Claim* If **you** are hospitalized (may include concurrent care claim of **hospital stays**)	No later than 24 hours after **we** receive the request, followed by written notification within 3 business days	Not applicable	Not applicable	Not applicable
Care to make sure **you** are stable following emergency treatment (post-stabilization) or for a life-threatening condition	No later than 1 hour after **we** receive the request	Not applicable	Not applicable	Not applicable
Requests for **step therapy** exception (non-emergency)	No later than 72 hours after **Imperial** receives the request	Not applicable	Not applicable	Not applicable
Requests for **step therapy** exception (emergency)	No later than 24 hours after **Imperial** receives the request	Not applicable	Not applicable	Not applicable

*If **we** approve the care and services, **we** will send **you** a letter no later than 2 business days after **we** receive the request. The *Adverse Determinations* section explains how and when **we** tell **you** about an adverse determination.

IMPORTANT NOTE:
We will tell **you** about the initial determination within the time appropriate to the circumstances relating to the delivery of the services and **your** condition. **We** will always tell **you** no later than the times shown in the chart above.

Adverse Determinations

We pay many claims at the full rate **negotiated charge** with a **network provider**, except for **your** share of the costs. However, in certain instances **we** pay only some of the claim or **we** do not pay at all. Any time **we** do not pay even part of the claim that is an "adverse determination" or "adverse decision." It is also an "adverse determination" if **we** rescind **your** coverage entirely.

An adverse determination is **our** determination that the health care services **you** have received, or may receive, are:

- **Experimental or investigational**
- Not **medically necessary**

If **we** deny health care services because **your provider** does not request **preauthorization,** a prospective or concurrent review or a concurrent claim extension, it is not an adverse determination.

Rescission means **you** lose coverage going forward and going backward. If **we** paid claims for **your** past coverage, **we** will recover the amounts paid.

If **we** make an adverse determination, **we** will tell **you** in writing. **Our** written decision will tell **you**:

- The main reason for the denial
- The clinical basis for the denial
- The source of the screening criteria used as a guideline to make the decision
- How to ask for an appeal of the denial, including **your** right to appeal to an independent review organization (IRO) and how to obtain an independent review
- How to obtain an immediate review by the IRO when the claim denial involves:
  - A life-threatening condition
  - The provision of **prescription drugs** or intravenous infusions for which the patient is receiving health benefits under the **EOC**

The chart below shows how much time **we** have to tell **you** about an adverse determination

Type Of Notice	When You Need Care To Make Sure You Are Stable Following Emergency Treatment (Post-Stabilization)	While You Are In The Hospital	When Not Hospitalized At The Time Of The Decision	Prescription Drugs Or Intravenous Infusions That You Are Currently Receiving	Retrospective
Initial Decision	No later than 1 hour after the request to the treating **provider**	Within 1 business day by phone or email to **your provider**, followed by written notice within three 3 business days to **you** and **your provider**	Within 3 business days to **you** and **your provider**	No later than the 30th day before the date on which the **prescription drugs** or intravenous infusions will be discontinued	Within 30 days after the date on which the claim is received
Extensions	Not applicable	Not applicable	Not applicable	Not applicable	15 days
Additional Information Request (**us**)	Not applicable	Not applicable	Not applicable	Not applicable	30 days
Response To Additional Information Request (**you**)	Not applicable	Not applicable	Not applicable	Not applicable	45 days

IMPORTANT NOTE:
We will advise **you** about an adverse determination within the time appropriate to the circumstances relating to the delivery of the services and **your** condition. **We** will advise **you** no later than the times shown in the chart above.

The Difference Between A Complaint And An Appeal

A Complaint

A complaint is any oral or written expression of dissatisfaction regarding any aspect of **our** operation. **You** may not be happy about a **provider** or an operational issue, and **you** may want to complain. **You** can call the number on **your** ID card or write **us**. See the *Have a complaint or need help?*section. For complaints about things handled by the Exchange, such as enrollment, **you** can call or write the Exchange to complain. Some other examples of complaints are when **you** are not happy with:

- How **we** have administered the plan

- How **we** have handled the appeal process
- When **we** deny a service that is not related to **medical necessity** issues
- The manner in which a service is provided
- A disenrollment decision

But it is not a complaint if:

- **We** resolve a misunderstanding or misinformation, to **your** satisfaction, by providing an explanation or more information.
- **You** or **your provider** call or write to tell **us you** are unhappy with, or disagree with, an adverse determination. Instead, this is an appeal of the adverse determination. See the *Appeal Of Adverse Determinations and Timeframes For Deciding Appeals Of Adverse Determinations* sections for more information.

Your complaint should include a description of the issue. **You** should include copies of any records or documents that **you** think are important. **We** will let **you** know that **we** have received **your** complaint within 5 business days. **Our** letter will tell **you** about **our** complaint procedures and timeframes. If **you** call **us** to complain, **we** will send **you** a complaint form to complete and return.

We will review the information and provide **you** with a written response within 30 calendar days of receiving the complaint. If **your** complaint is for services that **you** have not already received, **we** will provide **you** with a written response within 15 calendar days of receiving the complaint. **We** will let **you** know if **we** need more information to make a decision.

If **your** complaint concerns an emergency, or denial of continued hospitalization or **prescription drugs** and intravenous infusions, **we** will investigate and provide resolution not later than one business day or 72 hours, whichever is less, after receiving the complaint.

We will not engage in any retaliatory action against **you**, including termination or refusal to renew this **EOC**, because **you** have reasonably filed a complaint against **us** or appealed a decision from **us**. **We** shall not retaliate against a **physician** or **provider**, including termination or refusal to renew their contract, because the **physician** or **provider** has, on behalf of a Member, reasonably filed a complaint against the **us** or appealed a decision from **us**.

An Appeal

Your request to reconsider an adverse determination is an appeal of an adverse determination. It is also an appeal if **you** ask **us** to re-review a complaint because **you** are not happy with **our** initial response. The *Appeal Of A Complaint and Appeal Of Adverse Determinations* sections below explain the appeal processes for both types of appeals.

An Appeal Of A Complaint

You, someone who represents **you** or **your** provider can ask **us** to re-review **your** complaint. This is called an appeal. **You** can appeal to **us** by calling the toll-free number on **your** ID card or by writing Member Services.

We will let **you** know that **we** have received **your** appeal within 5 business days. This notice will describe

the appeals process and **your** rights. Part of this process is that **we** will assign a panel to review **your** appeal. **You** will have the opportunity to provide additional information for the panel to consider. **You** or an authorized representative can attend the appeal hearing in person or by telephone.

The panel will include an equal number of:

- Non-employee HMO members.
- HMO representatives who were not involved in making the initial decision.
- **Providers** (including **specialists**) who were not involved in the initial decision. **We** will use a **provider** with experience in the area of care that is disputed.

We will send **you** the following information at least 5 days before the appeal panel hearing, unless **you** agree otherwise:

- A copy of any documentation to be presented by **our** staff
- The specialties of the **physicians** or **providers** consulted during the review
- The name and affiliation of all HMO representatives on the appeal panel

The panel will review the information and provide **us** with their decision. **We** will send **you** the final decision in writing within 30 calendar days of receiving the appeal. If **your** appeal is for services that **you** have not already received, **we** will send **you** the final decision in writing within 15 calendar days of receiving the appeal. The letter will include:

- The date **we** received the appeal request
- The panel's understanding of **your** complaint and the facts
- The clinical basis and criteria used to make the decision
- Documents supporting the decision
- If applicable, a statement of **your** right to request an independent review
- A statement of **your** right to appeal to the Department of Insurance at:

Texas Department of Insurance
P.O. Box 12030
Austin, TX 78711-2030
1-800-252-3439

If **your** appeal of a complaint concerns an emergency or denial of continued hospitalization, **we** will investigate and provide resolution not later than one business day or 72 hours, whichever is less, after receiving the appeal of the complaint.

Due to the ongoing emergency or continued hospitalization and at **your** request, **we** will provide a review by a **physician** or **provider** instead of a review panel who:

- Has not previously reviewed the case
- Is of the same or a similar specialty as the **physician** or **provider** who would typically manage the medical condition, procedure or treatment under consideration for the review of the appeal

The **physician** or **provider** may interview the patient or patient's authorized representative and shall decide the appeal. The initial notice of the decision of the appeal may be given orally by the **physician** or **provider** if a written notice of the decision is also provided not later than the third day after the decision is made.

If **you** ask, **we** will give **you** or **your** representative reasonable access to appeal information. This includes all documents, records and other information **we** used to decide the claim or appeal. **We** will not charge **you** for the information.

Appeals Of Adverse Determinations

You can appeal **our** adverse determination. **We** will assign **your** appeal to someone who was not involved in making the original decision.

You can appeal by sending a written appeal to the address on the notice of adverse determination. Or **you** can call the number on **your** ID card. **You** need to include:

- The member's name
- A copy of the adverse determination
- **Your** reasons for making the appeal
- Any other information **you** would like **us** to consider

Another person may submit an appeal for **you**, including a **provider**. That person is called an authorized representative. **You** need to tell **us** if **you** choose to have someone else appeal for **you** (even if it is **your provider**). **You** should fill out an authorized representative form telling **us** that **you** are allowing someone to appeal for **you**. **You** may obtain this form on **our** website (see the *Have a complaint or need help?*section), or by calling the number on **your** ID card. The form will tell **you** where to send it to **us**. **You** can use an authorized representative at any level of appeal.

You can appeal one time under this **EOC**.

We will let **you** know that **we** have received **your** appeal of the adverse determination within 5 business days. This notice will describe the appeals process and **your** rights. If **you** call **us** to appeal, **we** will send **you** an appeal form to complete and return.

The review and decision of **your** appeal will be made by personnel not involved in making the initial adverse determination.

Expedited Internal Appeal

You are entitled to an expedited internal appeal process for emergency care denials, denials of care for life-threatening conditions, and denials of continued **stays** in a **hospital**. **You** can also ask for an expedited internal appeal if **we** deny **prescription drugs** or intravenous infusions **you** are currently receiving.

IMPORTANT NOTE:
You can skip **our** standard and expedited internal appeal process and instead appeal to an independent review organization (IRO) in certain situations. See the *Exhaustion Of Appeal Process* section.

Timeframes For Deciding Appeals Of Adverse Determination

The amount of time that **we** have to tell **you** about **our** decision on an appeal claim depends on the type of claim. The chart below shows a timetable view of the different types of claims and how much time **we**

have to tell **you** about **our** decision. **We** may tell **you** about **our** decision orally or in writing. If **we** tell **you** orally, **we** will also send **you** a letter within 3 calendar days after the oral notice.

Type Of Claim	**Our Response Time From Receipt Of Appeal**
When **you** need care to make sure **you** are stable following emergency treatment (post-stabilization)	No later than one (1) hour after the request
If **you** are hospitalized at the time of the adverse determination (may include concurrent care claim of **hospital stays**)	No later than 1 business day or 72 hours whichever is less*
If **you** are receiving **prescription drugs** or intravenous infusions	As soon as possible but not later than 1 b**us**iness day or 72 hours whichever is less
Requests for **step therapy** exception (non-emergency)	Within 72 hours after **Imperial** receives the request
Type of claim	**Our response time from receipt of appeal**
Requests for **step therapy** exception (emergency)	Within 24 hours after **Imperial** receives the request
Acquired brain **injury**	No later than 3 business days after the request, including a request for an extension of coverage based on medical necessity or appropriateness
Retrospective claim	As soon as possible but not later than 30 calendar days*

*If **your** appeal is denied, **your provider** may ask **us** to have a certain type of specialty **provider** review **your** case. The request must be made not later than 10 business days after the appeal was denied. A **provider** of the same or a similar specialty who would typically manage this type of condition will do the review. A decision will be made within 15 working days of the date **we** receive such a request.

Exhaustion Of Appeals Process

In most situations, **you** must complete the one level of appeal with **us** before **you** can take these other actions:

- Appeal through an independent review process.
- Pursue voluntary arbitration, litigation or other type of administrative proceeding.

Sometimes **you** do not have to complete the one level appeals process before **you** may take other actions. These are when:

- **You** have an urgent claim or a claim that involves ongoing treatment. **You** can have **your** claim reviewed internally and at the same time through the independent review process.
- **We** did not follow all of the claim determination and appeal requirements of Texas or Federal Department of Health and Human Services. However, **you** will not be able to proceed directly to independent review if the:
  - Rule violation was minor and unlikely to influence a decision or harm **you**

  - Violation was for a good cause or beyond **our** control
  - Violation was part of an ongoing, good faith exchange between **you** and **us**.
- **You** have a life-threatening condition. **You** can have **your** appeal reviewed through the independent review process.
- If **you** are receiving **prescription drugs** or intravenous infusion treatment and **we** deny them. **You** can have **your** appeal reviewed through the independent review process.

Independent Review

Independent review is a review done by people in an organization outside of Imperial. This is called an independent review organization (IRO).

You have a right to independent review only if:

- **Our** claim decision involved medical judgment
- **We** decided the service or supply is not **medically necessary** or inappropriate
- **We** decided the service or supply is **experimental or investigational**
- **You** have received an adverse determination

If **our** claim decision is one for which **you** can seek independent review, **we** will say that in the notice of adverse determination or final adverse determination **we** send **you**. That notice also will describe the independent review process. It will include a copy of the Request for Review by an Independent Review Organization (IRO) form at the final adverse determination level.

You must submit the Request for Review by an Independent Review Organization (IRO) Form:

- To Imperial;
- Within 4 months of the date **you** received the decision from **us**; and
- **You** must include a copy of the notice from **us** and all other important information that supports **your** request

You will pay for any information that **you** send and want reviewed by the IRO. **We** will pay for information **we** send to the IRO plus the cost of the review.

Imperial will contact the IRO that will conduct the review of **your** claim. If **your** request is based on exigent circumstances **your** request will be sent as soon as possible. An “exigent circumstance” means when **you** are:

- Experiencing a health condition that may seriously jeopardize **your** life, health or ability to regain maximum function
- Undergoing a current course of treatment using a non-formulary drug

The IRO will:

- Assign the appeal to one or more independent clinical reviewers that have the proper expertise to do the review
- Consider appropriate credible information that **you** sent
- Follow **our** contractual documents and **your** plan of benefits
- Send notification of the decision within 45 calendar days of the date **we** receive **your** request form and all the necessary information

We will stand by the decision that the IRO makes, unless **we** can show conflict of interest, bias or fraud.

How Long Will It Take To Get An IRO Decision?

We will tell **you** of the IRO decision not more than 45 calendar days after **we** receive **your** Notice of Independent Review Form with all the information **you** need to send in.

Sometimes **you** can get a faster external review decision. **Your provider** must call **us** or send **us** a Request for External Review Form.

You may be able to get a faster independent review after an adverse determination if:

- **Your provider** tells **us** that a delay in **your** receiving health care services would:
  - Jeopardize **your** life, health or ability to regain maximum function
  - Be much less effective if not started right away (**experimental or investigational** treatment)
- The adverse determination concerns:
  - An admission, availability of care, continued **stay** or health care service for which **you** received **emergency services**, but have not been discharged from a facility
  - A request for step therapy exceptions
  - A request for intravenous infusions **you** are currently receiving

If **your** situation qualifies for this faster review, **you** will receive a decision within 72 hours of **us** receiving **your** request or within 24 hours if **your** request is for an exigent circumstance.

Recordkeeping

We maintain the records of all complaints and appeals for a minimum of 10 years.

Fees And Expenses

We do not pay any fees or expenses incurred by **you** when **you** submit a complaint or appeal. But **we** will pay the fees or expenses incurred for the review of the IRO.

SECTION 11 – COORDINATION OF BENEFITS (COB)

This **EOC** does not coordinate benefits with any other policies, except for any Medicare coverage or plan **you** may have. Please see the *If **You** Become Eligible For Medicare* section of *General Provisions – Other Things **You** Should Know* for more information.

IMPERIAL INSURANCE COMPANIES

SECTION 12 – 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 **EOC** will end if:

- This **EOC** is discontinued. Coverage ends 90 days after **we** notify **you** of the termination
- **You** are no longer eligible for coverage including moving out of the **service area** Coverage ends 30 days after **we** notify **you** of the termination
- **You** voluntarily stop **your** coverage by notifying the Exchange or the Company
- **You** no longer meet the eligibility requirements of the Exchange including moving out of the **service area**
- **You** do not pay the required **premium** payment by the end of the grace period. Coverage ends on the last date for which the **premium** was paid or as of the date required by law
- This product is discontinued in the state, if approved by the insurance department of the state where this **EOC** was issued. Coverage ends 90 days after **we** notify **you** of the termination
- **We** withdraw from the individual market in the state, if approved by the insurance department of the state where this **EOC** was issued. Coverage ends 180 days after **we** notify **you** of the termination
- **We** rescind **your** coverage, as permitted under this **EOC**

However, the federal COBRA law usually applies to employers of group sizes of 20 or more and gives **you** and most of **your** 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.

Additionally, **you** have a group continuation privilege. This means that **you** may continue coverage if **your** coverage ends for any reason except involuntary termination for cause or discontinuance of the group agreement, as long as you have been covered for at least 3 months in row right before **your** coverage ends.

You can continue coverage until the earliest of:

- Six months after the end of the COBRA continuation period, if **you** are eligible for COBRA
- Nine months after the date election is made, if **you** are not eligible for COBRA
- The date **you** fail to pay premiums

- The date the group coverage terminates in its entirety
- The date **you** are covered for similar benefits by another health insurance policy or program
- The date **you** are covered (other than COBRA) for similar benefits by another plan

You must give **you**r employer written election of continuation no more than 60 days following the later of the date **your** coverage ends or the date that **you** were given notice by the contract holder

When Coverage Will End For Any Dependents

Dependent coverage will end if:

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

Notice Of Coverage Ending

The Exchange will send **you** notice if **your** coverage is ending. This notice will tell **you** the date that coverage ends. Coverage will end immediately on the next **premium** contribution due date following the date on which **you** no longer meet the eligibility requirements, unless y**ou** or **your** dependents are covered under COBRA or state continuation.

When We Would End Coverage

We may end **your** coverage upon 30 days advance written notice to **you** if **you** perform an act, practice, or omission that constitutes fraud, or make an intentional misrepresentation of a material fact when **you** applied for or got coverage. **You** can refer to the *General Provisions – Other Things **You** Should Know* section for more information.

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

SECTION 13 – GENERAL PROVISIONS – OTHER THINGS YOU SHOULD KNOW

Administrative Provisions

How We Will Interpret This EOC

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

If the **EOC** contains any provision or a part of a provision not in conformity with the Texas Insurance Codes (Insurance Code Chapter 1271) or other applicable laws, the remaining provision or parts of provisions are not rendered invalid. The remaining provisions or parts of provisions that are valid must be construed and applied as if they were in compliance with the Texas Insurance Codes (Insurance Code Chapter 1271) and other applicable laws.

How We Administer This EOC

We apply policies and procedures **we** have developed to administer this **EOC**.

Who's Responsible To You

We are responsible to **you** for what **our** employees and other agents do.

We are not responsible for what is done by **your providers**. They are not **our** employees or agents.

Coverage And Services

Your Coverage Can Change

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

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

Financial Sanctions Exclusions

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

If You Become Eligible For Medicare

If **you** are eligible for Medicare Part B **we** will base **our** payment for **eligible health services** on the benefits covered under Medicare Part B that **you** are eligible for. **We** will do this even if **you** are not enrolled in

Medicare Part B. Medicare will be the primary payor for the **eligible health services**.

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

Workers' Compensation

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

These recovery rights will be applied even though:

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

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

Legal Action

You must complete the internal appeal process before **you** take any legal action against **us** for any expense or bill. See the *When **You** Disagree - Claim Decisions And Appeal Procedures* section in **your EOC**. **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 **EOC**.

Following The Law

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

When You Are No Longer The Subscriber

If **you** are no longer the subscriber and the **EOC** was not cancelled, **your** covered spouse or domestic partner may become the subscriber upon notification to the Marketplace or **us** as long as **you** continue to pay the premium. If there is no subscriber at the end of a **premium** period, the **EOC** will be cancelled.

Child-Only Coverage

In the case of child-only coverage, the parent or legal guardian in whose name the coverage under the **EOC** is issued is considered the subscriber. As a parent or legal guardian, the subscriber has subscribed on behalf of the child for the benefits described in this **EOC**. It is the subscriber's responsibility to make sure the child fulfills all terms and conditions outlined in this **EOC**.

Effect Of Benefits Under Other Policies

Non-duplication of benefits

If, while covered under this **EOC**, **you** are covered by another Imperial individual coverage **EOC**:

- **You** have a right only to benefits of the **EOC** with the better benefits
- **We** will refund any **premium** charges **you** paid for the **EOC** with the lesser benefits during the time **you** were covered by both plans

Physical Examinations And Evaluations

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

Records Of Expenses

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

Things that would be important to keep are:

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

Honest Mistakes And Intentional Deception

Honest Mistakes

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

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

Intentional Deception

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

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

We also may report fraud to criminal authorities.

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

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

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

Financial Issues

Assignment Of Benefits

When **you** see a **network provider**, the **network provider** will usually bill **us** directly. When **you** see an **out-of-network provider we** may choose to pay **you** or to pay the **provider** directly. To the extent allowed by **applicable law**, **we** will not accept an assignment to an **out-of-network provider**.

Recovery Of Overpayments

In certain instances, **we** may overpay for **eligible health services** or pay for something that this **EOC** 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.

When You Are Injured By A Third Party

If a third party caused **you** to need care – for example, a driver who injured **you** in a car crash – **you** may have a legal right to get money for **your injuries**. If **you** have a legal right to get money from a third party for causing **your injuries**, then **we** are entitled to that money, up to the amount **we** pay for **your** care.

When **you** have a legal right to get money from one or more third parties for causing **your injuries**:

- **You** are agreeing to repay **us** from money **you** receive from those third parties because of **your injuries**
- **You** are giving **us** a right to seek money in **your** name, from those third parties because of **your injuries**
- **You** are agreeing to cooperate with **us** so **we** can get paid back in full, up to the applicable amount noted below. For example, you will tell **us** within 30 days of when **you** seek money from those third parties for **your injuries** or **illness**. **You** will hold any money **you** receive until **we** are paid in full. **You** will give **us** the right to **our** portion of the money **you** get, ahead of everyone else.
- **You** are agreeing to provide **us** notice of any money **you** will be receiving before pay out or within 5 days of when **you** receive the money.

We will only seek money from **your** own uninsured/underinsured motorist or medical payments coverage (if any) if **you** or **your** immediate family member did not pay **premiums** for the coverage.

If **you** are not represented by an attorney, then **we** can recover the lesser of:

- One-half of the money **you** receive, or
- The total amount paid by **us**

If **you** are represented by an attorney, then **we** can recover the lesser of:

- One-half of the money **you** receive, less attorney's fees and costs for the recovery, or

- The total amount paid by **us**, less attorney's fees and costs for the recovery

How Will Attorney's Fees Be Determined?	
If **we** do not use an attorney	• **We** (and any other payors) will pay **your** attorney a fee agreed to between **us** (and other payors) and **your** attorney plus a pro rata share of the recovery expenses. • If no agreement exists, then the court will award **your** attorney a reasonable fee payable for **our** (and any other payors') share of the recovery, not to exceed 1/3 of the recovery.
If **we** use an attorney	• The court will award attorney's fees to **our** attorney and **your** attorney based on the benefit accruing as a result of each attorney's service. The total attorney's fees may not exceed 1/3 of **our** (and any other payors') recovery.
Payor means a plan issuer that: • Has a contractual right of subrogation, and • Pays benefits to **you** or on **your** behalf as a result of personal injuries caused by someone else's tortious conduct A payor includes, but is not limited to, an issuer of: • A health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness • A disability benefit plan • An employee welfare benefit plan	

Your Health Information

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