

BENEFIT PLAN

Prepared Exclusively for
SAMPLE CO., INC.

PPO Medical

What Your Plan
Covers and How
Benefits are Paid

Innovation Health Insurance Company



Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-888-877-0943.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Innovation Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Innovation Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Innovation Health provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call 1-888-877-0943.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),

1-800-648-7817, TTY: 711,

Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Innovation Health is the brand name used for products and services provided Innovation Health Insurance Company and/or Innovation Health Plan, Inc. Innovation Health is an affiliate of Inova and Aetna Life Insurance Company and its affiliates. Aetna and its affiliates provide certain management services to Innovation Health.

Language Assistance

TTY: 711

For language assistance in English call 1-888-877-0943 at no cost. (English)

Para obtener asistencia lingüística en español, llame sin cargo al 1-888-877-0943 . (Spanish)

欲取得繁體中文語言協助，請撥打1-888-877-0943，無需付費。(Chinese)

Pour une assistance linguistique en français appeler le 1-888-877-0943 sans frais. (French)

Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-888-877-0943 nang walang bayad. (Tagalog)

T'áá shí shizaad k'ehjí bee shiká a'doowol nínízingo Diné k'ehjí koji' t'áá jíik'e hólné' 1-888-877-0943 (Navajo)

Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-888-877-0943 an. (German)

Për asistencë në gjuhën shqipe telefononi falas në 1-888-877-0943 . (Albanian)

በአማርኛ ቋንቋ ለግብርና 1-888-877-0943 በነጻ ይደውሉ (Amharic)

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-888-877-0943. (Arabic)

Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-888-877-0943 առանց գնով: (Armenian)

Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-888-877-0943 ku busa. (Bantu-Kirundi)

Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-888-877-0943 nga walay bayad. (Bisayan-Visayan)

বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-888-877-0943 -তে কল করুন। (Bengali-Bangala)

ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-888-877-0943 ကို ခေါ်ဆိုပါ။ (Burmese)

Per rebre assistència en (català), truqui al número gratuït 1-888-877-0943 . (Catalan)

Para ayuda gi fino' (Chamoru), ágang 1-888-877-0943 sin gástu. (Chamorro)

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(Chahta) anumpa ya apela a chi l paya hinla 1-888-877-0943 . (Choctaw)

Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-888-877-0943 irratti bilisaan bilbilaa. (Cushite)

Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-888-877-0943 . (Dutch)

Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-888-877-0943 gratis. (French Creole)

Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-888-877-0943 χωρίς χρέωση. (Greek)

(Gujarati) ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-888-877-0943 પર કોલ કરો.

No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-888-877-0943 . Kāki ‘ole ‘ia kēia kōkua nei. (Hawaiian)

(Hindi) हिन्दी में भाषा सहायता के लिए, 1-888-877-0943 पर मुफ्त कॉल करें।

Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-888-877-0943 . (Hmong)

Maka enyemaka asụsụ na Igbo kpọọ 1-888-877-0943 na akwughị ụgwọ ọ bụla (Ibo)

Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-888-877-0943 nga awan ti bayadanyo. (Ilocano)

Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-888-877-0943 tanpa dikenakan biaya. (Bahasa Indonesia)

Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-888-877-0943 . (Italian)

日本語で援助をご希望の方は、1-888-877-0943 まで無料でお電話ください。 (Japanese)

လၢတၢ်မၤတၢ်ကတိၤကျိၣ်အီၣ် ကိၣ် 1-888-877-0943 လၢတၢ်အိၣ်ဒီးတၢ်လၢၢ်တၢ်လၢၢ်တၢ်လၢၢ် (Karen)

한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-877-0943 번으로 전화해 주십시오.
(Korean)

Bé m̃ ké gbo-kpá-kpá dyé pídyi dé Bǎsòò-wùdùùn wěe, dǎ 1-888-877-0943 (Kru-Bassa)

بۆ وەرگرتنی رێنوێنی پێوەندیدار بە زمان بە زمان بە ژمارە 1-888-877-0943 بە خۆرای پێوەندی بکەن. (Kurdish)

ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-888-877-0943
ໂດຍບໍ່ເສຍຄ່າໂທ. (Laotian)

तील भाषा (मराठी) सहाय्यासाठी 1-888-877-0943 क्रमांकावर कोणत्याही खर्चाशिवाय कॉल करा. (Marathi)

Nān bōk jipāñ ilo Kajin Majol, kallok 1-888-877-0943 ilo ejjelok wōnān. (Marshallese)

Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-888-877-0943 ni sohte isais.
(Micronesian-Pohnpeian).

សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-888-877-0943 ដោយឥតគិតថ្លៃ។ (Mon-Khmer, Cambodian)

(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-888-877-0943 मा फोन गर्नुहोस्। (Nepali)

Tën kuɔɔny ë thok ë Thuɔɔnjǎŋ cɔl 1-888-877-0943 kecɪn ayöc. (Nilotic-Dinka)

For språkassistanse på norsk, ring 1-888-877-0943 kostnadsfritt. (Norwegian)

Fer Hefle in Deitsch, ruf: 1-888-877-0943 aa. Es Aaruf koschtet nix. (Pennsylvanian Dutch)

برای راهنمایی به زبان فارسی با شماره 1-888-877-0943 بدون هیچ هزینه ای تماس بگیرید. انگلیسی (Persian)

Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-888-877-0943 . (Polish)

Para obter assistência linguística em português ligue para o 1-888-877-0943 gratuitamente.
(Portuguese)

(Punjabi) ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-888-877-0943 'ਤੇ ਮੁਫਤ ਕਾਲ ਕਰੋ।

Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-888-877-0943 (Romanian)

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-888-877-0943 . (Russian)

Mo fesoasoani tau gagana I le Gagana Samoa vala’au le 1-888-877-0943 e aunoa ma se totogi. (Samoan)

Fún ìrànlowọ nípa èdè (Yorùbá) pe 1-888-877-0943 láí san owó kankan rárá. (Yoruba)

Important Information about the Affordable Care Act (ACA)

Non-discrimination Rule

The Office of Civil Rights recently issued a Non-discrimination Rule in response to Section 1557 of the Affordable Care Act (ACA). Section 1557 prohibits discrimination because of race, color, national origin, sex, age or disability in health-related insurance or other health-related coverage. This applies to Innovation Health. Changes to health insurance plans are effective on the first day of the policy or plan year beginning on or after January 1, 2017.

Some language changes may not be in the enclosed certificate of coverage or policy. This may be because the language is still under official review for approval. See the *Important note* below for how this affects your policy or plan.

Important note:

We will comply with the requirements of the Rule for all new and renewing policies or plans with an effective date on or after January 1, 2017.

Below is a summary of some of the recent Non-discrimination Rule changes.

An insurer covered by the Rule that provides or administers health-related insurance or other health-related coverage:

- Shall not:
 - Cancel, limit or refuse to issue or renew a policy or plan
 - Deny or limit coverage of a claim
 - Apply additional cost sharing

to a person because of race, color, national origin, sex, age, or disability.

- Shall not:
 - Deny or limit coverage
 - Deny or limit coverage of a claim
 - Apply additional cost sharing

to a transgender person, if it results in discrimination against that person.

- Shall not exclude or limit health services related to gender transition.

Innovation Health is the brand name used for products and services provided by Innovation Health Insurance Company and/or Innovation Health Plan, Inc. Innovation Health is an affiliate of Inova and Aetna Life Insurance Company and its affiliates. Aetna and its affiliates provide certain management services to Innovation Health. Aetna companies that receive funds from the federal Department of Health and Human Services are subject to the Rule.

Important Information About Your Plan

Coverage of Applied Behavior Analysis For the Treatment of Autism Spectrum Disorder

Your Plan includes coverage for the diagnosis and treatment of autism spectrum disorder. 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.

As part of this coverage, 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, and
- That are responsible for observable improvements in behavior.

Applied behavioral analysis will be subject to the same cost sharing requirements as other, outpatient services provided by a behavioral health provider for the treatment of autism spectrum disorder.

Important notes:

For plans that did not include such coverage previously, applied behavior analysis for the treatment of autism spectrum disorder will be an eligible health service for all new and renewing policies or plans with an effective date on or after January 1, 2017.

Applied behavior analysis requires precertification by Aetna.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates.

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*Defines the Terms Shown in Bold Type in the Text of This Document.

Preface (GR-96782 02-005 05 VA)

Innovation Health Insurance Company (Innovation Health) is pleased to provide you with this *Booklet-Certificate*. Read this *Booklet-Certificate* carefully. The plan is underwritten by Innovation Health Insurance Company of Falls Church, Virginia (referred to as Innovation Health, We, Our, or Us).

This *Booklet-Certificate* is part of the *Group Insurance Policy* between Us and the Policyholder. The *Group Insurance Policy* determines the terms and conditions of coverage. We agree with the Policyholder to provide coverage in accordance with the conditions, rights, and privileges as set forth in this *Booklet-Certificate*. The Policyholder selects the products and benefit levels under the plan. A person covered under this plan and their covered dependents are subject to all the conditions and provisions of the *Group Insurance Policy*.

The *Booklet-Certificate* describes the rights and obligations of you and Us, what the plan covers and how benefits are paid for that coverage. It is your responsibility to understand the terms and conditions in this *Booklet-Certificate*. Your *Booklet-Certificate* includes the *Schedule of Benefits* and any amendments or riders.

If you become insured, this *Booklet-Certificate* becomes your *Certificate of Coverage* under the *Group Insurance Policy*, and it replaces and supersedes all certificates describing similar coverage by Us that were previously issued to you.

Group Policyholder:	SAMPLE CO., INC.
Group Policy Number:	IHGP-SAMPLE
Effective Date:	January 1, 2018
Issue Date:	SAMPLE
Booklet-Certificate Number:	SAMPLE

Health Expense Coverage (GR-96782 02 020 02)

Benefits are payable for covered health care expenses that are incurred by you or your covered dependents while coverage is in effect. An expense is “incurred” on the day you receive a health care service or supply.

Coverage under this plan is non-occupational. Only **non-occupational injuries** and **non-occupational illnesses** are covered. Conditions that are related to pregnancy may be covered under this Plan.

Refer to the *What the Plan Covers* section of the *Booklet-Certificate* for more information about your coverage.

Treatment Outcomes of Covered Services (GR-96782 02-020 02)

We are not a provider of health care services and therefore are not responsible for and do not guarantee any results or outcomes of the covered health care services and supplies you receive. Except for Our RX Home Delivery LLC, providers of health care services, including **hospitals**, institutions, facilities or agencies, are independent contractors and are neither agents nor employees of Us or Our affiliates.

Important Information Regarding Availability of Coverage (GR-96782 02-020 02)

No benefits are covered under this *Booklet-Certificate* in the absence of payment of current premiums subject to the *Grace Period* and the *Premium* section of the *Group Insurance Policy*.

Unless specifically provided in any applicable termination or continuation of coverage provision described in this *Booklet-Certificate* or under the terms of the *Group Insurance Policy*, the plan does not pay benefits for a loss or claim for a health care, medical or dental care expense incurred before coverage starts under this plan.

This plan will not pay any benefits for any claims, or expenses incurred after the date this plan terminates.

This provision applies even if the loss, or expense, was incurred because of an **accident, injury or illness** that occurred, began or existed while coverage was in effect.

Please refer to the sections, “*Termination of Coverage (Extension of Benefits)*” and “*Continuation of Coverage*” for more details about these provisions.

Benefits may be modified during the term of this plan as specifically provided under the terms of the *Group Insurance Policy* or upon renewal. If benefits are modified, the revised benefits (including any reduction in benefits or elimination of benefits) apply to any expenses incurred for services or supplies furnished on or after the effective date of the plan modification. There is no vested right to receive any benefits described in the *Group Insurance Policy* or in this *Booklet-Certificate* beyond the date of termination or renewal including if the service or supply is furnished on or after the effective date of the plan modification, but prior to your receipt of amended plan documents.

When Your Coverage Begins

(GR96782 29-005 05)

Who Can Be Covered

How and When to Enroll

When Your Coverage Begins

Throughout this section you will find information on who can be covered under the plan, how to enroll and what to do when there is a change in your life that affects coverage. In this section, “you” means the employee to whom this *Booklet Certificate* is issued and whose insurance is in force under the terms of this group insurance policy.

Who Can Be Covered

Employees

To be covered by this plan, the following requirements must be met:

- You will need to be in an “eligible class”, as defined below; and
- You will need to meet the “eligibility date criteria” described below.

Determining if You Are in an Eligible Class (GR96782 29-005 05)

You are in an eligible class if:

- You are a regular full-time employee, as defined by your employer.

Determining When You Become Eligible (GR96782 29-005 05)

You become eligible for the plan on your eligibility date, which is determined as follows.

On the Effective Date of the Plan

If you are in an eligible class on the effective date of this plan, your coverage eligibility date is the effective date of the plan.

After the Effective Date of the Plan

If you are hired after the effective date of this plan, your coverage eligibility date is the date you are hired.

If you enter an eligible class after the effective date of this plan, your coverage eligibility date is the date you enter the eligible class.

Obtaining Coverage for Dependents (GR96782 29-010 12 VA)

Your dependents can be covered under this Plan. You may enroll the following dependents:

- Your spouse.
- Your dependent children.
- Your domestic partner who meets the rules set by your employer.
- Dependent children of your domestic partner.

We will rely upon your employer to determine whether or not a person meets the definition of a dependent for coverage under this Plan. This determination will be conclusive and binding upon all persons for the purposes of this Plan.

Coverage for a Domestic Partner (GR96782 29-010 12 V.A)

To be eligible for coverage, a domestic partner must meet the following criteria:

A domestic partner is a person who certifies the following as of the date of enrollment:

- He or she is your sole domestic partner and intends to remain so indefinitely.
- He or she is not married or legally separated from anyone else.
- He or she has not registered as a member of another domestic partnership within the past six months.
- He or she is of the age of consent in your state of residence.
- He or she is not a blood relative to a degree of closeness that would prohibit legal marriage in the state in which you legally reside.
- He or she has cohabitated and resided with you in the same residence for the past six months and intends to cohabitate and reside with you indefinitely.
- He or she is engaged with you in a committed relationship of mutual caring and support, and is jointly responsible for your common welfare and living expenses.
- He or she is not in the relationship solely for the purpose of obtaining the benefits of coverage.
- He or she can demonstrate interdependence with you by submitting proof of at least three of the following:
 - Common ownership of real property (joint deed or mortgage agreement) or a common leasehold interest in property;
 - Common ownership of a motor vehicle;
 - Driver's license listing a common address;
 - Proof of joint bank accounts or credit accounts;
 - Proof of designation as the primary beneficiary for life insurance or retirement benefits, or primary beneficiary designation under your will; or
 - Assignment of a durable property power of attorney or health care power of attorney.

Coverage for Dependent Children (GR96782 29-010 12 V.A)

To be eligible for coverage, a dependent child must be under 26 years of age.

(GR96782 29-010 12 V.A)

An eligible dependent child includes:

- Your biological children;
- Your stepchildren;
- Your legally adopted children;
- Your foster children, including any children placed with you for adoption;
- Any children for whom you are responsible under court order;
- Your grandchildren in your court-ordered custody; and
- Any other child with whom you have a parent-child relationship.

Coverage for Handicapped Children

Coverage for a handicapped child may be continued past the age limits shown above. See the provision *Handicapped Dependent Children* in the *Continuation of Coverage* section of this *Booklet-Certificate* for more information.

Important Reminder

Keep in mind that you cannot receive coverage under this Plan as:

- Both an employee and a dependent; or
- A dependent of more than one employee.

How and When to Enroll (GR96782 29-015 07 VA)

Initial Enrollment in the Plan

You will be provided with plan benefit and enrollment information when you first become eligible to enroll. You will need to enroll in a manner determined by Us and your employer. To complete the enrollment process, you will need to provide all requested information for yourself and your eligible dependents.

You will also need to agree to make required contributions for any contributory coverage. Your employer will determine the amount of your plan contributions, which you will need to agree to before you can enroll. Your employer will advise you of the required amount of your contributions and will deduct your contributions from your pay. Remember plan contributions are subject to change.

You and your dependents (current or newly acquired) must enroll within 31 days of your eligibility date. If you or your dependents are not enrolled during this time period, it may affect your contributions or eligibility for coverage under this plan. You may be considered a **Late Enrollee**. If you miss the enrollment period, you will not be able to participate in the plan until the next annual enrollment period, unless you qualify under a Special Enrollment Period, as described below.

If you do not enroll for coverage when you first become eligible, but wish to do so later, your employer will provide you with information on when and how you can enroll.

Newborns are automatically covered for 31 days starting on the date of birth. To continue coverage after 31 days, after birth, you will need to complete a change form and return it to your employer within the 31 days following birth.

Late Enrollment

If you do not enroll during the Initial Enrollment Period, or a subsequent annual enrollment period, you and your eligible dependents may be considered **Late Enrollees** and coverage may be deferred until the next annual enrollment period. If, at the time of your initial enrollment, you elect coverage for yourself only and later request coverage for your eligible dependents, they may be considered **Late Enrollees**.

You must return your completed enrollment form before the end of the next annual enrollment period.

However, you and your eligible dependents may not be considered **Late Enrollees** under the circumstances described in the “Special Enrollment Periods” section below.

Annual Enrollment (GR96782 029-15 07 VA)

During the annual enrollment period, you will have the opportunity to review your coverage needs for the upcoming year. During this period, you have the option to change your coverage. The choices you make during this annual enrollment period will become effective the following year.

If you do not enroll yourself or a dependent for coverage when you first become eligible, but wish to do so later, you will need to do so during the next annual enrollment period, unless you qualify under one of the Special Enrollment Periods, as described below.

Special Enrollment Periods (GR96782 029-15 07 VA)

You will not be considered a **Late Enrollee** if you qualify under a Special Enrollment Period as defined below. If one of these situations applies, you may enroll before the next annual enrollment period.

Loss of Other Health Care Coverage

You or your dependents may qualify for a Special Enrollment Period if:

- You did not enroll yourself or your dependent when you first became eligible or during any subsequent annual enrollments because, at that time:
 - You or your dependents were covered under other creditable coverage; and
 - You refused coverage and stated, in writing, at the time you refused coverage that the reason was that you or your dependents had other creditable coverage; and
- You or your dependents are no longer eligible for other creditable coverage because of one of the following:
 - The end of your employment;
 - A reduction in your hours of employment (for example, moving from a full-time to part-time position);
 - The ending of the other plan's coverage;
 - Death;
 - Divorce or legal separation;
 - Employer contributions toward that coverage have ended;
 - COBRA coverage ends;
 - The employer's decision to stop offering the group health plan to the eligible class to which you belong;
 - Cessation of a dependent's status as an eligible dependent as such is defined under this Plan;
 - With respect to coverage under Medicaid or an S-CHIP Plan, you or your dependents no longer qualify for such coverage; or
 - The operation of another Plan's lifetime maximum on all benefits, if applicable.

You or your dependents become eligible for State premium assistance, with respect to coverage under the group health plan, under Medicaid or an S-CHIP Plan.

You will need to enroll yourself or a dependent for coverage within:

- 31 days of when other creditable coverage ends;
- within 60 days of when coverage under Medicaid or an S-CHIP Plan ends; or
- within 60 days of the date you or your dependents become eligible for Medicaid or S-CHIP premium assistance.

Evidence of termination of creditable coverage must be provided to Us. If you do not enroll during this time, you will need to wait until the next annual enrollment period.

New Dependents

You and your dependents may qualify for a Special Enrollment Period if:

- You did not enroll when you were first eligible for coverage; and
- You later acquire a dependent, as defined under the plan, through marriage, birth, adoption, or placement for adoption; and
- You elect coverage for yourself and your dependent within 31 days of acquiring the dependent.

Your spouse or child who meets the definition of a dependent under the plan may qualify for a Special Enrollment Period if:

- You did not enroll them when they were first eligible; and
- You later elect coverage for them within 31 days of a court order requiring you to provide coverage.

You will need to report any new dependents by completing a change form, which is available from your employer. The form must be completed and returned to Us within 31 days of the change. If you do not return the form within 31 days of the change, you will need to make the changes during the next annual enrollment period.

If You Adopt a Child

Your plan will cover a child who is placed for adoption. This means you have taken on the legal obligation for total or partial support of a child whom you plan to adopt.

Your plan will provide coverage for a child who is placed with you for adoption if:

- The child meets the plan's definition of an eligible dependent on the date he or she is placed for adoption; and
- You request coverage for the child in writing within 31 days of the placement;
- Proof of placement will need to be presented to Us prior to the dependent enrollment;
- Any coverage limitations for a preexisting condition will not apply to a child placed with you for adoption provided that the placement occurs on or after the effective date of your coverage.

When You Receive a Qualified Child Support Order

A Qualified Medical Child Support Order (QMCSO) is a court order requiring a parent to provide health care coverage to one or more children. Your plan will provide coverage for a child, who is covered under a QMCSO, if:

- The child meets the plan's definition of an eligible dependent; and
- You request coverage for the child in writing within 31 days of the court order.

Coverage for the dependent will become effective on the date of the court order. Any coverage limitations for a preexisting condition will not apply, as long as you submit a written request for coverage within the 31-day period.

If you do not request coverage for the child within the 31-day period, you will need to wait until the next annual enrollment period.

Under a QMCSO, if you are the non-custodial parent, the custodial parent may file claims for benefits. Benefits for such claims will be paid to the custodial parent.

When Your Coverage Begins (GR96782 29-025 05)

Your Effective Date of Coverage

If you have met all the eligibility requirements, your coverage takes effect on the later of:

- The date you are eligible for coverage; and
- The date you return your completed enrollment information; and
- Your application is received and approved in writing by Us; and
- The date your required contribution is received by Us.

Important Notice:

- You must pay the required contribution in full.
- As to Health Expense coverage, if you do not return your completed and signed enrollment information within 31 days of your eligibility date, the rules under the *Special or Late Enrollment Periods* section will apply.

Your Dependent's Effective Date of Coverage (GR96782 29-025 05)

Your dependent's coverage takes effect on the same day that your coverage becomes effective, if you have enrolled them in the plan.

Important Notes: New dependents must be reported to Us within 31 days of becoming eligible. If you or your dependents are not enrolled within this time period, it may affect your contributions or eligibility for coverage under this Plan. As to Health Expense Coverage, if you do not report a new dependent within 31 days of his or her eligibility date, the rules under the *Special or Late Enrollment Periods* section will apply.

How Your Medical Plan Works

(GR-96782 08-005 01)

Common Terms

Accessing Providers

Precertification

It is important that you have the information and useful resources to help you get the most out of your medical plan. This *Booklet-Certificate* explains:

- Definitions you need to know;
- How to access care, including procedures you need to follow;
- What expenses for services and supplies are covered and what limits may apply;
- What expenses for services and supplies are not covered by the plan;
- How you share the cost of your covered services and supplies; and
- Other important information such as eligibility, complaints and appeals, termination, continuation of coverage, and general administration of the plan.

Important Notes

- Unless otherwise indicated, “you” refers to you and your covered dependents.
- Your health plan pays benefits only for services and supplies described in this *Booklet-Certificate* as **covered expenses** that are **medically necessary**.
- This *Booklet-Certificate* applies to coverage only and does not restrict your ability to receive health care services that are not or might not be covered benefits under this health plan.
- Store this *Booklet-Certificate* in a safe place for future reference.

Common Terms (GR-96782 08-010 01)

Many terms throughout this Booklet-Certificate are defined in the *Glossary* section at the back of this document. Defined terms appear in bolded print. Understanding these terms will also help you understand how your plan works and provide you with useful information regarding your coverage.

About Your PPO Medical Plan (GR-96782 08-020 06 V/A)

This Preferred Provider Organization (PPO) medical plan provides coverage for a wide range of medical expenses for the treatment of **illness** or **injury**. It does not provide benefits for all medical care. The plan also provides coverage for certain preventive and wellness benefits. With your PPO plan, you can directly access any network or out-of-network **physician, hospital** or other health care provider for covered services and supplies under the plan. The plan pays benefits differently when services and supplies are obtained through **network providers** or **out-of-network providers** under this Plan.

The plan will pay for **covered expenses** up to the maximum benefits shown in this *Booklet-Certificate*. Coverage is subject to all the terms, policies and procedures outlined in this *Booklet-Certificate*. Not all medical expenses are covered under the plan. Exclusions and limitations apply to certain medical services, supplies and expenses. Refer to the *What the Plan Covers, Exclusions, Limitations* and *Schedule of Benefits* sections to determine if medical services are covered, excluded or limited.

This PPO plan provides access to covered services and supplies through a broad network of health care providers and facilities. The plan is designed to lower your out-of-pocket costs when you use **network providers** for **covered expenses**. Your **deductibles**, **copayments**, and **coinsurance** will generally be lower when you use participating **network providers** and facilities.

You also have the choice to access licensed **providers, hospitals** and facilities outside of the networks for covered services and supplies. Your out-of-pocket costs will generally be higher when you use **out-of-network providers** because the **deductibles**, **copayments**, and **coinsurance** are usually higher when you utilize **out-of-network providers**. **Out-of-network providers** have not agreed to accept the **negotiated charge** and may balance bill you for charges over the amount We pay under the plan.

Your out-of-pocket costs may vary between network and out-of-network benefits. Read your *Schedule of Benefits* carefully to understand the cost sharing charges applicable to you.

Availability of Providers

We cannot guarantee the availability or continued participation of a particular provider. Either We or any **network provider** may terminate the **provider** contract or limit the number of patients accepted in a practice. If the **physician** initially selected cannot accept additional patients, you will be notified and given an opportunity to make another selection.

Ongoing Reviews

We conduct ongoing reviews of those services and supplies which are recommended or provided by health professionals to determine whether such services and supplies are covered benefits under this *Booklet-Certificate*. If We determine that the recommended services or supplies are not covered benefits, you will be notified. You may appeal such determinations by contacting Us to seek a review of the determination. Please refer to the *Reporting of Claims* section of this *Booklet-Certificate* and the *Appeals Procedure* section in this *Booklet-Certificate*.

To better understand the choices that you have with your PPO plan, please carefully review the following information.

How Your PPO Plan Works (GR-96782 08-025 06)

Accessing Network Providers and Benefits

- You may select any **network provider** from the **directory** or by logging on to **Our** website www.innovation-health.com. You can search Our online **directory**, DocFind®, for names and locations of **physicians** and other health care providers and facilities. You can change your health care provider at any time.
- If a service you need is covered under the plan but not available from a **network provider**, please contact Member Services at the toll-free number on your ID card for assistance.
- Certain health care services such as **hospitalization, outpatient surgery** and certain other outpatient services, require **precertification** with Us to verify coverage for these services. You do not need to **precertify** services provided by a **network provider**. **Network providers** will be responsible for obtaining necessary **precertification** for you. Since **precertification** is the provider's responsibility, there is no additional out-of-pocket cost to you as a result of a **network provider's** failure to **precertify** services. Refer to the *Understanding Precertification* section for more information.
- You will not have to submit medical claims for treatment received from **network providers**. Your **network provider** will take care of the claim submission. We will directly pay the **network provider** less any cost sharing required by you. You will be responsible for **deductibles**, **coinsurance**, and **copayment** amounts, if any.
- You will receive notification of what the plan has paid toward your **covered expenses**. It will indicate any amounts you owe toward your **deductible**, **copayment**, or **coinsurance** amounts or other non-covered expenses you have incurred. You may elect to receive this notification by e-mail, or through the mail. Call or e-mail Member Services if you have questions regarding your statement.

Cost Sharing For Network Benefits

Important Note:

You share in the cost of your benefits. Cost Sharing amounts and provisions are described in the *Schedule of Benefits*.

- **Network providers** have agreed to accept the **negotiated charge**. We will reimburse you for a **covered expense**, incurred from a **network provider**, up to the **negotiated charge** and the maximum benefits under this Plan, less any cost sharing required by you such as **deductibles**, **copayments** and **coinsurance**. Your **coinsurance** is based on the **negotiated charge**. You will not have to pay any balance bills above the **negotiated charge** for that covered service or supply.
- You must satisfy any applicable **deductibles** before the plan will begin to pay benefits.
- **Deductibles** and **coinsurance** are usually lower when you use **network providers** than when you use **out-of-network providers**.
- For certain types of services and supplies, you will be responsible for any **copayment** shown in the *Schedule of Benefits*.
- After you satisfy any applicable **deductible**, you will be responsible for your **coinsurance** for **covered expenses** that you incur. You will be responsible for your **coinsurance** up to the **maximum out-of-pocket limit** applicable to your plan.
- Once you satisfy any applicable **maximum out-of-pocket limit**, the plan will pay 100% of the **covered expenses** that apply toward the limit for the rest of the Calendar Year. Certain designated out-of-pocket expenses may not apply to the **maximum out-of-pocket limit**. Refer to your *Schedule of Benefits* section for information on what **covered expenses** do not apply to the **maximum out-of-pocket limit** and for the specific **maximum out-of-pocket limit** amounts that apply to your plan.
- The plan will pay for **covered expenses**, up to the maximums shown in the *What the Plan Covers* or *Schedule of Benefits* sections. You are responsible for any expenses incurred over the maximum limits outlined in the *What the Plan Covers* or *Schedule of Benefits* sections.
- You may be billed for any **deductible**, **copayments**, or **coinsurance** amounts, or any non-covered expenses that you incur.

Accessing Out-of-Network Providers and Benefits

- You have the choice to directly access **out-of-network providers**. You will still be covered when you access **out-of-network providers** for **covered benefits**. When your medical service is provided by an **out-of-network provider**, the level of reimbursement from the plan for **covered expenses** will usually be lower. This means your out-of-pocket costs will generally be higher.
- Certain health care services such as **hospitalization**, **outpatient surgery** and certain other outpatient services, require **precertification** with Us to verify coverage for these services. When you receive services from an **out-of-network provider**, you are responsible for obtaining the necessary **precertification** from Us. Your **provider** may **precertify** your treatment for you. However you should verify with Us prior to the services, that the provider has obtained **precertification** from Us. If the service is not **precertified**, the benefit payable may be significantly reduced or may not be covered. This means you will be responsible for the unpaid balance of any bills. You must call the **precertification** toll-free number on your ID card to **precertify** services. Refer to the *Understanding Precertification* section for more information on the **precertification** process and what to do if your request for **precertification** is denied.
- When you use **out-of-network providers**, you may have to pay for services at the time they are rendered. You may be required to pay the full charges and submit a claim form for reimbursement. You are responsible for completing and submitting claim forms for reimbursement of **covered expenses** you paid directly to an **out-of-network provider**.

- When you pay you pay an **out-of-network provider** directly, you will be responsible for completing a claim form to receive reimbursement of **covered expenses** from Us. You must submit a completed claim form and proof of payment to Us. Refer to the *General Provisions* section of this *Booklet-Certificate* for a complete description of how to file a claim under this plan.
- You will receive notification of what the plan has paid toward your **covered expenses**. It will indicate any amounts you owe towards any **deductible** or **coinsurance** amounts, or other non-covered expenses you have incurred. You may elect to receive this notification by e-mail, or through the mail. Call or e-mail Member Services if you have questions regarding your statement.

Important Note

Failure to **precertify** services and supplies provided by an **out-of-network provider** will result in a reduction of benefits or no coverage for the services and supplies under this *Booklet-Certificate*. Please refer to the *Understanding Precertification* section for information on how to request **precertification**.

Cost Sharing for Out-of-Network Benefits

Important Note:

You share in the cost of your benefits. Cost Sharing amounts and provisions are described in the *Schedule of Benefits*.

- **Out-of-network providers** have not agreed to accept the **negotiated charge**. We will reimburse you for a **covered expense**, incurred from an **out-of network provider**, up to the **recognized charge** and the maximum benefits under this Plan, less any cost-sharing required by you such as **deductibles** and **payment percentage**. The **recognized charge** is the maximum amount We will pay for a **covered expense** from an **out-of-network provider**. Your **payment percentage** will be based on the **recognized charge**. If your **out-of-network provider** charges more than the **recognized charge**, you will be responsible for any expenses above the **recognized charge**. Except for emergency services, We will only pay up to the **recognized charge**.
- You must satisfy any applicable **deductibles** before the plan begins to pay benefits.
- **Deductibles** and **payment percentage** are usually higher when you use **out-of-network providers** than when you use **network providers**.
- After you satisfy any applicable **deductible**, you will be responsible for any applicable **coinsurance** for **covered expenses** that you incur. You will be responsible for your **coinsurance** up to the **maximum out-of-pocket limit** applicable to your plan.
- Once you satisfy any applicable **maximum out-of-pocket limit**, the plan will pay 100% of the **covered expenses** that apply toward the limit for the rest of the Calendar Year. Certain designated out-of-pocket expenses may not apply to the **maximum out-of-pocket limit**. Refer to your *Schedule of Benefits* section for information on what **covered expenses** do not apply to the **maximum out-of-pocket limit** and for the specific **maximum out-of-pocket limit** amounts that apply to your plan.
- The plan will pay for **covered expenses**, up to the maximums shown in the *What the Plan Covers* section or the *Schedule of Benefits*. You are responsible for any expenses incurred over the maximum limits outlined in the *What the Plan Covers* section or the *Schedule of Benefits*.
- You may be billed for any **deductible** or **coinsurance** amounts, or any non-covered expenses that you incur.

Understanding Precertification (GR-96782 08-060 02 V4)

Precertification

Certain services, such as inpatient **stays**, certain tests, procedures and **outpatient surgery** require **precertification** by Us. **Precertification** is a process that helps you and your **physician** determine whether the services being recommended are **covered expenses** under the plan. It also allows Us to help your provider coordinate your transition from an inpatient setting to an outpatient setting (called discharge planning), and to register you for specialized programs or case management when appropriate.

You do not need to **precertify** services provided by a **network provider**. **Network providers** will be responsible for obtaining necessary **precertification** for you. Since **precertification** is the provider's responsibility, there is no additional out-of-pocket cost to you as a result of a **network provider's** failure to **precertify** services.

When you go to an **out-of-network provider**, it is your responsibility to obtain **precertification** from Us for any services or supplies on the **precertification** list below. If you do not **precertify**, your benefits may be reduced, or the plan may not pay any benefits. The list of services requiring **precertification** follows on the next page.

Important Note

Please read the following sections in their entirety for important information on the **precertification** process, and any impact it may have on your coverage.

The Precertification Process

Prior to being **hospitalized** or receiving certain other medical services or supplies there are certain **precertification** procedures that must be followed.

You are responsible for obtaining **precertification** for services provided by an **out-of-network provider**. You or a member of your family, a **hospital** staff member, or the attending **physician**, must notify Us to **precertify** the admission or medical services and expenses prior to receiving any of the services or supplies that require **precertification** pursuant to this *Booklet-Certificate* in accordance with the following timelines:

Precertification should be secured within the timeframes specified below. To obtain **precertification**, call Us at the telephone number listed on your ID card. This call must be made:

For non-emergency admissions:	It is your responsibility to call and request precertification at least 14 days before the date you are scheduled to be admitted.
For an urgent admission :	You, your physician or the facility will need to call before you are scheduled to be admitted. An urgent admission is a hospital admission by a physician due to the onset of or change in an illness ; the diagnosis of an illness ; or an injury .
For outpatient non-emergency medical services requiring precertification :	You or your physician must call at least 14 days before the outpatient care is provided, or the treatment or procedure is scheduled.

We will provide a written notification to you and your **physician** of the **precertification** decision. If your **precertified** expenses are approved the approval is good for 60 days as long as you remain enrolled in the plan.

When you have an inpatient admission to a facility, We will notify you, your **physician** and the facility about your **precertified** length of **stay**. If your **physician** recommends that your **stay** be extended, additional days will need to be certified. You, your **physician**, or the facility will need to call Us at the number on your ID card as soon as reasonably possible, but no later than the final authorized day. We will review and process the request for an extended **stay**. You and your **physician** will receive a notification of an approval or denial.

If **precertification** determines that the **stay** or services and supplies are not **covered expenses**, the notification will explain why and how Our decision can be appealed. You or your provider may request a review of the **precertification** decision pursuant to the *Appeals Procedure* section of this *Booklet-Certificate*.

Services and Supplies Which Require Precertification (GR-96782 08-065 04)

Precertification is required for the following types of medical expenses:

Inpatient and Outpatient Care

- Stays in a **hospital**
- Stays in a **skilled nursing facility**
- Stays in a **rehabilitation facility**

- Stays in a **hospice facility**
- Outpatient **hospice care**
- Stays in a **residential treatment facility** for treatment of mental disorders, alcoholism or drug abuse treatment
- **Home health care**
- Private duty nursing care

How Failure to Precertify Affects Your Benefits (GR-96782 08-070 02)

A **precertification** benefit reduction will be applied to the benefits paid if you fail to obtain a required **precertification** prior to incurring medical expenses. This means We will reduce the amount paid towards your coverage, or your expenses may not be covered. You will be responsible for the unpaid balance of the bills.

You are responsible for obtaining the necessary **precertification** from Us prior to receiving services from an **out-of-network provider**. Your provider may **precertify** your treatment for you; however you should verify with Us prior to the procedure, that the provider has obtained **precertification** from Us. If your treatment is not **precertified** by you or your provider, the benefit payable may be significantly reduced or your expenses may not be covered.

How Your Benefits are Affected

The chart below illustrates the effect on your benefits if necessary **precertification** is not obtained.

If precertification is:	then the expenses are:
▪ requested and approved by Us	▪ covered.
▪ requested and denied.	▪ not covered, may be appealed.
▪ not requested, but would have been covered if requested.	▪ covered after a precertification benefit reduction is applied.*
▪ not requested, would not have been covered if requested.	▪ not covered, may be appealed.

It is important to remember that any additional out-of-pocket expenses incurred because your **precertification** requirement was not met will not count toward your **deductible** or **Maximum Out of Pocket Limit**.

*Refer to the *Schedule of Benefits* section for the amount of **precertification** benefit reduction that applies to your plan.

Emergency and Urgent Care (GR-96782 27-005 01)

You have coverage 24 hours a day, 7 days a week, anywhere inside or outside the plan's service area, for:

- An **emergency medical condition**; or
- An **urgent condition**.

In Case of a Medical Emergency

A recent and severe medical condition, including (but not limited to) severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, **illness** or **injury** is of such a nature that failure to get immediate medical care could result in:

- Placing your health in serious jeopardy; or
- Serious impairment to bodily function; or
- Serious dysfunction of a body part or organ; or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

When **emergency care** is necessary, please follow the guidelines below:

- Seek the nearest emergency room, or dial 911 or your local emergency response service for medical and ambulatory assistance. If possible, call your **physician** provided a delay would not be detrimental to your health.
- After assessing and stabilizing your condition, the emergency room should contact your **physician** to obtain your medical history to assist the emergency **physician** in your treatment.
- If you are admitted to an inpatient facility, notify your **physician** as soon as reasonably possible.
- If you seek care in an emergency room for a non-emergency condition (one that does not meet the criteria above), the plan will not cover the expenses you incur. Please refer to the *Schedule of Benefits* for specific details about the plan.

Coverage for Emergency Medical Conditions

The plan will pay for **hospital** services provided in an emergency room to evaluate and treat an **emergency medical condition**.

The **emergency care** benefit covers:

- Use of emergency room facilities;
- Emergency room staff **physicians'** services;
- **Hospital** nursing staff services; and
- Staff radiologists and pathologists services.

Please contact your **physician** after receiving treatment of an **emergency medical condition**.

Important Reminder

If you visit a **hospital** emergency room for a non-emergency condition, the plan will not cover your expenses, as shown in the *Schedule of Benefits*. No other plan benefits will pay for non-emergency care in the emergency room unless otherwise specified under the Plan.

In Case of an Urgent Condition (GR-96782 27-010 01)

This means a sudden **illness, injury** or condition that:

- Is severe enough to require prompt medical attention to avoid serious deterioration of your health;
- Includes a condition which would subject you to severe pain that could not be adequately managed without urgent care or treatment;
- Does not require the level of care provided in the emergency room of a **hospital**; and
- Requires immediate outpatient medical care that cannot be postponed until your physician becomes reasonably available.

Call your **physician** if you think you need urgent care. **Network providers** are required to provide urgent care coverage 24 hours a day, including weekends and holidays. You may contact any **physician** or **urgent care provider**, in- or out-of-network, for an **urgent care condition** if you cannot reach your **physician**.

If it is not feasible to contact your **network provider**, please do so as soon as possible after urgent care is provided. If you need help finding a **network urgent care provider** you may call Member Services at the toll-free number on your I.D. card, or you may access Our online provider directory at www.innovation-health.com.

Coverage for an Urgent Condition

The plan will pay for the services of a **hospital** or **urgent care provider** to evaluate and treat an **urgent condition**.

Your coverage includes:

- Use of urgent care facilities;

- **Physician** services;
- Nursing staff services; and
- Staff radiologists and pathologists services.

Non-Urgent Care

If you seek care from an **urgent care provider** for a non-**urgent condition**, (one that does not meet the criteria above), the plan will not cover the expenses you incur unless otherwise specified under the Plan. Please refer to the *Schedule of Benefits* for specific plan details.

Important Reminder

If you visit an **urgent care provider** for a non-**urgent condition**, the plan will not cover your expenses, as shown in the *Schedule of Benefits*. No other plan benefits will pay for non-urgent care received at a hospital or an urgent care provider unless otherwise specified.

Follow-Up Care After Treatment of an Emergency or Urgent Medical Condition

Follow-up care is not considered an emergency or **urgent condition** and is not covered as part of any emergency or urgent care visit. Once you have been treated and discharged, you should contact your **physician** for any necessary follow-up care.

For coverage purposes, follow-up care is treated as any other expense for **illness** or **injury**. If you access a **hospital** emergency room for follow-up care, your expenses will not be covered and you will be responsible for the entire cost of your treatment. Refer to your *Schedule of Benefits* for cost sharing information applicable to your plan.

To keep your out-of-pocket costs lower, your follow-up care should be provided by a **network provider**.

You may use an **out-of-network provider** for your follow-up care. You will be subject to the **deductible and coinsurance** that apply to out-of-network expenses, which may result in higher out-of-pocket costs to you.

Important Notice

Follow up care, which includes (but is not limited to) suture removal, cast removal and radiological tests such as x-rays, should **not** be provided by an emergency room facility.

Requirements for Coverage (GR-96782 09-005 01)

To be covered by the plan, services and supplies and **prescription drugs** must meet all of the conditions below:

1. The service or supply or **prescription drug** must be covered by the plan. For a service or supply or **prescription drug** to be covered, it must:
 - Be included as a **covered expense** in this *Booklet-Certificate*;
 - Not be an excluded expense under this *Booklet-Certificate*. Refer to the *Exclusions* sections of this *Booklet-Certificate* for a list of services and supplies that are excluded;
 - Not exceed the maximums and limitations outlined in this *Booklet-Certificate*. Refer to the *What the Plan Covers* section and the *Schedule of Benefits* for information about certain expense limits; and
 - Be obtained in accordance with all the terms, policies and procedures outlined in this *Booklet-Certificate*.
2. The service or supply or **prescription drug** must be provided while coverage is in effect. See the *Who Can Be Covered, How and When to Enroll, When Your Coverage Begins, When Coverage Ends* and *Continuation of Coverage* sections for details on when coverage begins and ends.
3. The service or supply or **prescription drug** must be **medically necessary**. To meet this requirement, the medical services, supply or **prescription drug** must be provided by a **physician**, or other health care provider, exercising prudent clinical judgment, to a patient for the purpose of preventing, evaluating, diagnosing or treating an **illness, injury**, disease or its symptoms. The provision of the service or supply must be:
 - (a) In accordance with generally accepted standards of medical practice;
 - (b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness, injury** or disease; and
 - (c) Not primarily for the convenience of the patient, **physician** or other health care provider;
 - (d) And not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's **illness, injury**, or disease.

For these purposes “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, or otherwise consistent with **physician** specialty society recommendations and the views of **physicians** practicing in relevant clinical areas and any other relevant factors.

Important Note

Not every service, supply or **prescription drug** that fits the definition for **medical necessity** is covered by the plan. Exclusions and limitations apply to certain medical services, supplies and expenses. For example some benefits are limited to a certain number of days, visits or a dollar maximum. Refer to the *What the Plan Covers* section and the *Schedule of Benefits* for the plan limits and maximums.

What The Plan Covers

(GR96782 11-001 01 V/A)

Wellness

Physician Services

Hospital Expenses

Other Medical Expenses

PPO Medical Plan

Many preventive and routine medical expenses as well as expenses incurred for a serious **illness** or **injury** are covered. This section describes which expenses are **covered expenses**. Only expenses incurred for the services and supplies shown in this section are **covered expenses**. Limitations and exclusions apply.

Preventive Care (GR96782 11-006 02)

This section on Preventive Care describes the **covered expenses** for services and supplies provided when you are well.

Important Notes:

1. The recommendations and guidelines of the:
 - Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
 - United States Preventive Services Task Force; and
 - Health Resources and Services Administration;as referenced throughout this *Preventive Care* section may be updated periodically. This Plan is subject to updated recommendations or guidelines that are issued by these organizations beginning on the first day of the plan year, one year after the recommendation or guideline is issued.
2. If any diagnostic x-rays, lab, or other tests or procedures are ordered, or given, in connection with any of the *Preventive Care* benefits described below, those tests or procedures will not be covered as *Preventive Care* benefits. Those tests and procedures that are **covered expenses** will be subject to the cost-sharing that applies to those specific services under this Plan.
3. Refer to the *Schedule of Benefits* for information about cost-sharing and maximums that apply to *Preventive Care* benefits.

(GR96782 07-006 02 V/A)

Routine Physical Exams

Covered expenses include charges made by your **physician** for routine physical exams. This includes routine vision and hearing screenings given as part of the routine physical 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 also 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.
- For females, 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, such as:
 1. Interpersonal and domestic violence;
 2. Sexually transmitted diseases; and

- 3. Human Immune Deficiency Virus (HIV) infections.
 - Screening for gestational diabetes.
 - High risk Human Papillomavirus (HPV) DNA testing for women age 30 and older.
- X-rays, lab and other tests given in connection with the exam.
- For covered newborns, an initial **hospital** checkup.

Limitations

Unless specified above, not covered under this *Preventive Care* benefit are charges for:

- Services which are covered to any extent under any other part of this Plan;
- Services which are for diagnosis or treatment of a suspected or identified **illness** or **injury**;
- Exams given during your **stay** for medical care;
- Services not given by a **physician** or under his or her direction;
- Psychiatric, psychological, personality or emotional testing or exams.

Preventive Care Immunizations (GR96782 11-006 02 V/A)

Covered expenses include charges made by your **physician** or a facility for:

- immunizations for infectious diseases; and
- the materials for administration of immunizations;

that have been recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

Childhood Immunization Expenses

In addition to the above covered medical expenses include charges incurred by a covered dependent child between the ages of birth and 36-months for all routine and necessary immunizations administered on an outpatient basis.

Routine and necessary immunizations mean immunizations against diphtheria, pertussis, tetanus, polio, hepatitis B, measles, mumps, rubella, and other such immunizations as may be prescribed by the Virginia Commissioner of Health.

Limitations

Not covered under this *Preventive Care* benefit are charges incurred for:

- Services which are covered to any extent under any other part of this Plan; and
- Immunizations that are not considered *Preventive Care* such as those required due to your employment or travel.

Well Woman Preventive Visits (GR-96782 11-006 02 V/A)

Covered expenses include charges made by your **physician** for a routine well woman preventive exam office visit, including Pap smears, and testing using any FDA-approved gynecological cytology screening technologies in accordance with the recommendations by the Health Resources and Services Administration. A routine well woman preventive 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**.

Limitations

Unless specified above, not covered under this *Preventive Care* benefit are charges for:

- Services which are covered to any extent under any other part of this Plan;
- Services which are for diagnosis or treatment of a suspected or identified **illness** or **injury**;
- Exams given during your **stay** for medical care;
- Services not given by a **physician** or under his or her direction;
- Psychiatric, psychological, personality or emotional testing or exams.

Routine Cancer Screenings (GR96782 11-006 02 V.A)

Covered expenses include, but are not limited to, charges incurred for routine cancer screening as follows:

- Mammograms;
- Fecal occult blood tests;
- Digital rectal exams;
- Prostate specific antigen (PSA) tests;
- Sigmoidoscopies;
- Double contrast barium enemas (DCBE); and
- Colonoscopies.

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; and
- Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration.

Although not included in the guidelines recommended by the United States Preventive Services Task Force or the guidelines supported by the Health Resources and Services Administration, this Plan also covers the following:

- One baseline mammogram for a woman age 35 but less than age 40; and
- Digital rectal exams and prostate specific antigen (PSA) tests for covered person's age 40 and over who are at high risk for prostate cancer.

In connection with an annual exam for screening of colorectal cancer and provided in accordance with the most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations:

- Fecal occult blood test; and
- Flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging.

Limitations

Unless specified above, not covered under this *Preventive Care* benefit are charges incurred for:

- Services which are covered to any extent under any other part of this Plan.

Important Notes:

1. Refer to the *Schedule of Benefits* for details about cost sharing and benefit maximums that apply to Preventive Care.
2. For details on the frequency and age limits that apply to *Routine Physical Exams* and *Routine Cancer Screenings*, contact your **physician**, log onto the Our website www.innovation-health.com, or call Member Services at the number on the back of your ID card.

Screening and Counseling Services (GR-96782 11-006 02 V.A)

Covered expenses include charges made by your **physician** in an individual or group setting for the following:

Obesity

Screening and counseling services to aid in weight reduction due to obesity. Coverage includes:

- Preventive counseling visits and/or risk factor reduction intervention;
- Medical nutrition therapy;

- Nutrition counseling; and
- Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease.

Benefits for the screening and counseling services above are subject to the visit maximums shown in your *Schedule of Benefits*.

Misuse of Alcohol and/or Drugs

Screening and counseling services to aid in the prevention or reduction of the use of an alcohol agent or controlled substance. Coverage includes preventive counseling visits, risk factor reduction intervention and a structured assessment.

Benefits for the screening and counseling services above are subject to the visit maximums shown in your *Schedule of Benefits*.

Use of Tobacco Products

Screening and counseling services to aid you to stop the use of tobacco products.

Coverage includes:

- Preventive counseling visits;
- Treatment visits; and
- Class visits;

to aid you to stop the use of tobacco products.

Tobacco product means a substance containing tobacco or nicotine including:

- Cigarettes,
- Cigars;
- Smoking tobacco;
- Snuff; smokeless tobacco and
- Candy-like products that contain tobacco.

Benefits for the screening and counseling services above are subject to the visit maximums shown in your *Schedule of Benefits*.

Limitations

Unless specified above, not covered under this benefit are charges for:

- Services which are covered to any extent under any other part of this Plan.

Prenatal Care (GR96782 11-006 02 VA)

Prenatal care will be covered as *Preventive Care* for services received by a pregnant female in a **physician's**, obstetrician's, or gynecologist's office but only to the extent described below.

Coverage for prenatal care under this *Preventive Care* benefit is limited to pregnancy-related physician office visits including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure and fetal heart rate check).

Limitations

Unless specified above, not covered under this *Preventive Care* benefit are charges incurred for:

- Services which are covered to any extent under any other part of this Plan;
- Pregnancy expenses (other than prenatal care as described above).

Important Notes:

Refer to the *Pregnancy Expenses* and *Exclusions* sections of this *Booklet-Certificate* for more information on coverage for pregnancy expenses under this Plan, including other prenatal care, delivery and postnatal care office visits.

Comprehensive Lactation Support and Counseling Services (GR-96782 11-006 02 V.A)

Covered expenses include comprehensive lactation support (assistance and training in breast feeding) and counseling services provided to females during pregnancy and in the post partum period by a certified lactation support provider.

Covered expenses incurred also include the rental or purchase of breast feeding equipment as described below.

Lactation support and lactation counseling services are **covered expenses** when provided in either a group or individual setting. Benefits for lactation counseling services are subject to the visit maximum shown in your *Schedule of Benefits*.

Breast Feeding Durable Medical Equipment

Coverage includes the rental or purchase of breast feeding **durable medical equipment** for the purpose of lactation support (pumping and storage of breast milk) as follows.

Breast Pump

Covered expenses include the following:

- The rental of a hospital-grade electric pump for a newborn child when the newborn child is confined in a **hospital**.
- The purchase of:
 - An electric breast pump (non-hospital grade); or
 - A manual breast pump.
-

Breast Pump Supplies

Coverage is 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, and 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.

We reserve the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at Our discretion.

Limitations

Unless specified above, not covered under this *Preventive Care* benefit are charges incurred for services which are covered to any extent under any other part of this Plan.

Important Notes:

If a breast pump service or supply that you need is covered under this Plan but not available from a **network provider** in your area, please contact Member Services at the toll-free number on your ID card for assistance.

Family Planning Services - Female Contraceptives (GR96782 11-006 02 V.A)

For females with reproductive capacity, **covered expenses** include those charges incurred for services and supplies that are provided to prevent pregnancy. All contraceptive methods, services and supplies covered under this *Preventive Care* benefit must be approved by the U.S. Food and Drug Administration (FDA).

Coverage includes counseling services on contraceptive methods provided by a **physician**, obstetrician or gynecologist. Such counseling services are **covered expenses** when provided in either a group or individual setting. They are subject to the contraceptive counseling services visit maximum shown in your *Schedule of Benefits*.

The following contraceptive methods are **covered expenses** under this *Preventive Care* benefit:

Voluntary Sterilization

Covered expenses include charges billed separately by the provider for female voluntary sterilization procedures and related services and supplies including, but not limited to, tubal ligation and sterilization implants.

Covered expenses under this *Preventive Care* benefit would not include charges for a voluntary sterilization procedure to the extent that the procedure was not billed separately by the provider or because it was not the primary purpose of a confinement.

(GR96782 11-006 02 VA)

Contraceptives

Covered expenses include charges made by a **physician** for:

- Female contraceptives that are **generic prescription drugs**;
- Female contraceptive devices including the related services and supplies needed to administer the device.

Limitations:

Unless specified above, not covered under this *Preventive Care* benefit are charges for:

- Services which are covered to any extent under any other part of this Plan;
- Services and supplies incurred for an abortion;
- Services provided as a result of complications resulting from a voluntary sterilization procedure and related follow-up care;
- Services which are for the treatment of an identified **illness** or **injury**;
- Services that are not given by a **physician** or under his or her direction;
- Psychiatric, psychological, personality or emotional testing or exams;
- Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA;
- Male contraceptive methods, sterilization procedures or devices;
- The reversal of voluntary sterilization procedures, including any related follow-up care;
- Services and supplies furnished by an **out-of-network provider**.

Family Planning Services – Other (GR96782 11-007 01 VA)

Covered expenses include charges for certain family planning services, even though not provided to treat an **illness** or **injury**.

- Voluntary sterilization for males
- Voluntary termination of pregnancy

Limitations

Not covered are:

- Reversal of voluntary sterilization procedures, including related follow-up care;
- Charges for services which are covered to any extent under any other part of this Plan or any other group plans sponsored by your employer; and
- Charges incurred for family planning services while confined as an inpatient in a **hospital** or other facility for medical care.

Important Notes:

1. Refer to the *Schedule of Benefits* for details about cost sharing and benefit maximums that apply to Family Planning Services - Other.
2. For more information, see the sections on *Family Planning Services - Female Contraceptives*, *Pregnancy Expenses* and *Treatment of Infertility* in this *Booklet-Certificate*.

Vision Care Services (GR96782 11-010 01)

Covered expenses include charges made by a legally qualified ophthalmologist or optometrist for the following services:

- Routine eye exam: The plan covers expenses for a complete routine eye exam that includes refraction and glaucoma testing. A routine eye exam does not include a contact lens exam. The plan covers charges for one routine eye exam in any 24 consecutive month period.

Limitations

Coverage is subject to any applicable Calendar Year **deductibles**, **copays** and **coinsurance** percentages shown in your *Schedule of Benefits*.

Physician Services (GR96782 11-020 05 V/A)

Physician Visits

Covered expenses include charges made by a **physician** during a visit to treat an **illness** or **injury**. The visit may be at the **physician's** office, in your home, in a **hospital** or other facility during your **stay** or in an outpatient facility.

Covered expenses also include:

- Immunizations for infectious disease, but not if solely for your employment;
- Allergy testing, treatment and injections; and
- Charges made by the **physician** for supplies, radiological services, x-rays, and tests provided by the **physician**.

Important Note

For a description of the preventive care expenses covered under this Plan, refer to the *Preventive Care Benefits* section in this *Booklet-Certificate*.

Surgery

Covered expenses include charges made by a **physician** for:

- Performing your surgical procedure;
- Pre-operative and post-operative visits; and
- Consultation with another **physician** to obtain a second opinion prior to the surgery.

Anesthetics

Covered expenses include charges for the administration of anesthetics and oxygen by a **physician**, other than the operating **physician**, or Certified Registered Nurse Anesthetist (C.R.N.A.) in connection with a covered procedure.

Important Note

Certain procedures need to be **precertified** by Us. Refer to *How the Plan Works* for more information about **precertification**.

Alternatives to Physician Office Visits (GR96782 11-020 05 V.A)

Walk-In Clinic Visits

Covered expenses include charges made by **walk-in clinics** for:

- Unscheduled, non-emergency **illnesses** and **injuries**;
- The administration of certain immunizations administered within the scope of the clinic's license; and
- Individual screening and counseling services to aid you:
 - to stop the use of tobacco products; and
 - in weight reduction due to obesity.

Limitations:

Unless specified above, not covered under this benefit are charges incurred for services and supplies furnished:

- In a group setting for screening and counseling services.

Important Note:

- Not all services are available at all Walk-In Clinics. The types of services offered will vary by the provider and location of the clinic.
- For a complete description of the screening and counseling services provided on the use of tobacco products and to aid in weight reduction due to obesity, refer to the *Preventive Care Benefits* section in this *Booklet-Certificate* and the *Screening and Counseling Services* benefit for a description of these services. These services may also be obtained from your **physician**.

Telemedicine Services

Covered expenses include charges for the provision of health care services that are covered under this policy and are appropriately provided through **telemedicine services**.

Telemedicine Services, as it pertains to the delivery of health care services, means the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment. **Telemedicine services** do not include an audio-only telephone, electronic mail message, or facsimile transmission.

Hospital Expenses (GR96782 11-030 01)

Covered expenses include services and supplies provided by a **hospital** during your **stay**.

Room and Board

Covered expenses include charges for **room and board** provided at a **hospital** during your **stay**. Private room charges that exceed the **hospital's semi-private room rate** are not covered unless a private room is required because of a contagious **illness** or immune system problem.

Room and board charges also include:

- Services of the **hospital's** nursing staff;
- Admission and other fees;
- General and special diets; and
- Sundries and supplies.

Other Hospital Services and Supplies

Covered expenses include charges made by a **hospital** for services and supplies furnished to you in connection with your **stay**.

Covered expenses include hospital charges for other services and supplies provided, such as:

- **Ambulance** services.
- **Physicians** and surgeons.

- Operating and recovery rooms.
- Intensive or special care facilities.
- Administration of blood and blood products, but not the cost of the blood or blood products.
- Radiation therapy.
- Speech therapy, physical therapy and occupational therapy.
- Oxygen and oxygen therapy.
- Radiological services, laboratory testing and diagnostic services.
- Medications.
- Intravenous (IV) preparations.
- Discharge planning.

Outpatient Hospital Expenses (GR96782 11-030 01)

Covered expenses include **hospital** charges made for covered services and supplies provided by the outpatient department of a **hospital**.

Important Reminders

The plan will only pay for nursing services provided by the **hospital** as part of its charge. The plan does not cover private duty nursing services as part of an inpatient **hospital** stay.

If a **hospital** or other health care facility does not itemize specific **room and board** charges and other charges, We will assume that 40 percent of the total is for **room and board** charge, and 60 percent is for other charges.

Hospital admissions need to be **precertified** by Us. Refer to *How the Plan Works* for details about **precertification**.

In addition to charges made by the **hospital**, certain **physicians** and other providers may bill you separately during your **stay**. **Covered expenses** for these charges are payable at the **out-of-network** benefit level if the provider has not contracted with Us, even if the facility is in the network.

Refer to the *Schedule of Benefits* for details about any applicable **deductible**, **copay** and **coinsurance** and maximum benefit limits

Coverage for Emergency Medical Conditions (GR96782 11-035 01)

Covered expenses include charges made by a **hospital** or a **physician** for services provided in an emergency room to evaluate and treat an **emergency medical condition**.

The emergency care benefit covers:

- Use of emergency room facilities;
- Emergency room **physicians** services;
- **Hospital** nursing staff services; and
- Radiologists and pathologists services.

Please contact a **network provider** after receiving treatment for an **emergency medical condition**.

Important Reminder

With the exception of Urgent Care described below, if you visit a **hospital** emergency room for a non-emergency condition, the plan will not cover your expenses, as shown in the *Schedule of Benefits*. No other plan benefits will pay for non-emergency care in the emergency room.

Coverage for Urgent Conditions (GR96782 11-035 01)

Covered expenses include charges made by a **hospital** or **urgent care provider** to evaluate and treat an **urgent condition**.

Your coverage includes:

- Use of emergency room facilities when network urgent care facilities are not in the service area and you cannot reasonably wait to visit your **physician**;
- Use of urgent care facilities;
- **Physicians'** services;
- Nursing staff services; and
- Radiologists' and pathologists' services.

Please contact a **network provider** after receiving treatment of an **urgent condition**.

If you visit an **urgent care provider** for a non-**urgent condition**, the plan will not cover your expenses, as shown in the *Schedule of Benefits*.

Alternatives to Hospital Stays (GR96782 11-040 01 V/A)

Outpatient Surgery and Physician Surgical Services

Covered expenses include charges for services and supplies furnished in connection with outpatient surgery made by:

- A **physician** or **dentist** for professional services;
- A **surgery center**; or
- The outpatient department of a **hospital**.

The surgery must meet the following requirements:

- The surgery can be performed adequately and safely only in a **surgery center** or **hospital**; and
- The surgery is not normally performed in a **physician's** or **dentist's** office.

Important Note

Benefits for surgery services performed in a **physician's** or **dentist's** office are described under *Physician Services* benefits in the previous section.

The following outpatient surgery expenses are covered:

- Services and supplies provided by the **hospital**, **surgery center** on the day of the procedure;
- The operating **physician's** services for performing the procedure, related pre- and post-operative care, and administration of anesthesia; and
- Services of another **physician** for related post-operative care and administration of anesthesia. This does not include a local anesthetic.

Limitations

Not covered under this plan are charges made for:

- The services of a **physician** or other health care provider who renders technical assistance to the operating **physician**.
- A **stay** in a **hospital**.
- Facility charges for office based surgery.

Birth Center (GR96782 11-045 01)

Covered expenses include charges made by a **birth center** for services and supplies related to your care in a **birth center** for:

- Prenatal care;
- Delivery; and
- Postpartum care within 48 hours after a vaginal delivery and 96 hours after a Cesarean delivery.

Limitations

Unless specified above, not covered under this benefit are charges:

- In connection with a pregnancy for which pregnancy related expenses are not included as a **covered expense**.

See *Pregnancy Related Expenses* for information about other **covered expenses** related to maternity care.

Home Health Care (GR96782 11-050 01)

Covered expenses include charges for home health care services when ordered by a **physician** as part of a home health plan and provided you are:

- Transitioning from a **hospital** or other inpatient facility, and the services are in lieu of a continued inpatient **stay**;
or
- **Homebound**.

Covered expenses include only the following:

- **Skilled nursing services** that require medical training of, and are provided by, a licensed nursing professional within the scope of his or her license. These services need to be provided during intermittent visits of four hours or less, with a daily maximum of three visits. Intermittent visits are considered periodic and recurring visits that skilled nurses make to ensure your proper care, which means they are not on site for more than four hours at a time. If you are discharged from a **hospital** or **skilled nursing facility** after an inpatient **stay**, the intermittent requirement may be waived to allow coverage for up to 12 hours (three visits) of continuous **skilled nursing services**. However, these services must be provided for within 10 days of discharge.
- Home health aide services, when provided in conjunction with skilled nursing care, that directly support the care. These services need to be provided during intermittent visits of four hours or less, with a daily maximum of three visits.
- Medical social services, when provided in conjunction with skilled nursing care, by a qualified social worker.

Benefits for home health care visits are payable up to the Home Health Care Maximum. Each visit by a nurse or therapist is one visit.

In figuring the Calendar Year Maximum Visits, each visit of up to 4 hours is one visit.

This maximum will not apply to care given by an **R.N.** or **L.P.N.** when:

- Care is provided within 10 days of discharge from a **hospital** or **skilled nursing facility** as a full-time inpatient; and
- Care is needed to transition from the **hospital** or **skilled nursing facility** to home care.

When the above criteria are met, **covered expenses** include up to 12 hours of continuous care by an **R.N.** or **L.P.N.** per day.

Coverage for Home Health Care services is not determined by the availability of caregivers to perform them. The absence of a person to perform a non-skilled or **custodial care** service does not cause the service to become covered. If the covered person is a minor or an adult who is dependent upon others for non-skilled care (e.g. bathing, eating, toileting), coverage for home health services will only be provided during times when there is a family member or caregiver present in the home to meet the person's non-skilled needs.

Note: Home short-term physical, speech, or occupational therapy is covered when the above home health care criteria are met. Services are subject to the conditions and limitations listed in the Short-Term Rehabilitation Therapies section of the *Schedule of Benefits*.

Limitations

Unless specified above, not covered under this benefit are charges for:

- Services or supplies that are not a part of the **Home Health Care Plan**.
- Services of a person who usually lives with you, or who is a member of your or your spouse's or your domestic partner's family.
- Services of a certified or licensed social worker.
- Services for physical, occupational and speech therapy. Refer to *Short-Term Rehabilitation Therapy Services* section for coverage information.
- Services for infusion therapy.
- Transportation.
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present.
- Services that are **custodial care**.

Important Reminders

The plan does not cover **custodial care**, even if care is provided by a nursing professional, and family member or other caretakers cannot provide the necessary care.

Home health care needs to be **precertified** by Us. Refer to *How the Plan Works* for details about **precertification**.

Refer to the *Schedule of Benefits* for details about any applicable home health care visit maximums.

Skilled Nursing Care (GR96782 11-065 01)

Covered expenses include charges by an **R.N.** or **L.P.N.**, or nursing agency for outpatient skilled nursing care.

This is care by a visiting **R.N.** or **L.P.N.** to perform specific skilled nursing tasks.

Limitations

Unless specified above, not covered under this benefit are charges for:

- Nursing care that does not require the education, training and technical skills of a **R.N.** or **L.P.N.**
- Nursing care assistance for daily life activities, such as:
 - Transportation;
 - Meal preparation;
 - Vital sign charting;
 - Companionship activities;
 - Bathing;
 - Feeding;
 - Personal grooming;
 - Dressing;

- Toileting; and
- Getting in/out of bed or a chair.
- Nursing care provided for skilled observation.
- Nursing care provided while you are an inpatient in a **hospital** or health care facility.
- A service provided solely to administer oral medicine, except where law requires a **R.N.** or **L.P.N.** to administer medicines.

Skilled Nursing Facility (GR96782 11-060 01 VA)

Covered expenses include charges made by a **skilled nursing facility** during your **stay** for the following services and supplies, up to the maximums shown in the *Schedule of Benefits*, including:

- **Room and board**, up to the **semi-private room rate**. The plan will cover up to the private room rate if it is needed due to an infectious illness or a weak or compromised immune system;
- Use of special treatment rooms;
- Radiological services and lab work;
- Physical, occupational, or speech therapy;
- Oxygen and other gas therapy;
- Other medical services and general nursing services usually given by a **skilled nursing facility** (this does not include charges made for private or special nursing, or **physician's** services); and
- Medical supplies.

Important Reminder

Refer to the *Schedule of Benefits* for details about any applicable **skilled nursing facility** maximums.

Admissions to a **skilled nursing facility** must be **precertified** by Us. Refer to *Using Your Medical Plan* for details about **precertification**.

Limitations

Unless specified above, *not* covered under this benefit are charges for:

- Charges made for the treatment of:
 - Drug addiction;
 - Alcoholism;
 - Senility;
 - Intellectual disability or physical; or
 - Any other mental illness; and
- Daily **room and board** charges over the **semi private rate**.

Hospice Care (GR96782 11-070 01 VA)

Covered expenses include charges made by the following furnished to you for **hospice care** when given as part of a **hospice care program**.

Facility Expenses

The charges made by a **hospital**, **hospice** or **skilled nursing facility** for:

- **Room and Board** and other services and supplies furnished during a **stay** for pain control and other acute and chronic symptom management; and
- Services and supplies furnished to you on an outpatient basis.

Outpatient Hospice Expenses

Covered expenses include charges made on an outpatient basis by a **Hospice Care Agency** for:

- Part-time or intermittent nursing care by a **R.N.** or **L.P.N.** for up to eight hours a day;
- Part-time or intermittent home health aide services to care for you up to eight hours a day.
- Medical social services under the direction of a **physician**. These include but are not limited to:
 - Assessment of your social, emotional and medical needs, and your home and family situation;
 - Identification of available community resources; and
 - Assistance provided to you to obtain resources to meet your assessed needs.
- Physical and occupational therapy; and
- Consultation or case management services by a **physician**;
- Medical supplies;
- **Prescription drugs**;
- Dietary counseling; and
- Psychological counseling.

Charges made by the providers below if they are not an employee of a **Hospice Care Agency**; and such Agency retains responsibility for your care:

- A **physician** for a consultation or case management;
- A physical or occupational therapist;
- A **home health care agency** for:
 - Physical and occupational therapy;
 - Part-time or intermittent home health aide services for your care up to eight hours a day;
 - Medical supplies;
 - **Prescription drugs**;
 - Psychological counseling; and
 - Dietary counseling.

Limitations

Unless specified above, not covered under this benefit are charges for:

- Daily **room and board** charges over the **semi-private room rate**.
- 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. These include, but are not limited to: sitter or companion services for either you or other family members; transportation; maintenance of the house.

Important Reminders

Refer to the *Schedule of Benefits* for details about any applicable **hospice care** maximums.

Inpatient **hospice care** and home health care must be **precertified** by Us. Refer to *How the Plan Works* for details about **precertification**.

Other Covered Health Care Expenses (GR96782 11-080 01)

Acupuncture

The plan covers charges made for acupuncture services provided by a **physician**, if the service is performed:

- As a form of anesthesia in connection with a covered surgical procedure.

Important Reminder

Refer to the *Schedule of Benefits* for details about any applicable acupuncture benefit maximum.

Ambulance Service (GR96782 11-080 01)

Covered expenses include charges made by a professional **ambulance**, as follows:

Ground Ambulance

Covered expenses include charges for transportation:

- To the first **hospital** where treatment is given in a medical emergency.
- From one **hospital** to another **hospital** in a medical emergency when the first **hospital** does not have the required services or facilities to treat your condition.
- From **hospital** to home or to another facility when other means of transportation would be considered unsafe due to your medical condition.
- From home to **hospital** for covered inpatient or outpatient treatment when other means of transportation would be considered unsafe due to your medical condition. Transport is limited to 100 miles.
- During a covered inpatient **stay** at a **hospital, skilled nursing facility** or acute rehabilitation **hospital**, to transport you for inpatient or outpatient **medically necessary** treatment when an ambulance is required to safely and adequately transport you.

Air or Water Ambulance

Covered expenses include charges for transportation to a **hospital** by air or water **ambulance** when:

- Ground **ambulance** transportation is not available;
- Your condition is unstable, and requires medical supervision and rapid transport; and
- From one **hospital** to another **hospital** in a medical emergency when the first **hospital** does not have the required services or facilities to treat your condition; and the two conditions above are met.

Limitations

Not covered under this benefit are charges incurred to transport you:

- If an **ambulance** service is not required by your physical condition; or
- If the type of **ambulance** service provided is not required for your physical condition; or
- By any form of transportation other than a professional **ambulance** service.

Autism Spectrum Disorders (GR-96782 11-171 02 V/A)

Covered expenses include charges for the diagnosis and treatment of Autism Spectrum Disorder in covered individuals from age two through age six. Treatment of autism spectrum disorder shall be identified in a treatment plan and includes the following care prescribed or ordered for a covered individual diagnosed with autism spectrum disorder by a licensed **physician** or a licensed psychologist who determines the care to be **medically necessary**: (i) behavioral health treatment, (ii) pharmacy care, (iii) psychiatric care, (iv) psychological care, (v) therapeutic care, and (vi) applied behavioral analysis when provided by or supervised by a board certified behavior analyst who shall be licensed by the Board of Medicine.

“Applied Behavioral Analysis” means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between the environment and behavior.

“Autism Spectrum Disorder” means any pervasive developmental disorder, including:

- Autistic Disorder;
- Asperger's Syndrome;
- Rett's Syndrome;
- Childhood Disintegrative Disorder; or
- Pervasive Developmental Disorder--Not Otherwise Specified;

as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

“Behavioral health treatment” means professional, counseling, and guidance services and treatment programs that are necessary to develop, maintain, or restore to the maximum extent practicable, the functioning of an individual.

“Pharmacy care” means medications prescribed by a licensed **physician** and any health-related services deemed **medically necessary** to determine the need or effectiveness of the medications.

“Psychiatric care” means direct or consultative services provided by a **psychiatrist** licensed in the state in which the **psychiatrist** practices.

“Psychological care” means the direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.

“Therapeutic care” means services provided by licensed or certified speech therapists, occupational therapists, physical therapists, or clinical social workers.

“Treatment plan” means a plan for the treatment of autism spectrum disorder developed by a licensed **physician** or licensed psychologist pursuant to a comprehensive evaluation or reevaluation performed in a manner consistent with the most recent clinical report or recommendation of the American Academy of Pediatrics or the American Academy of Child and Adolescent Psychiatry.

Coverage for Applied Behavioral Analysis for the diagnosis and treatment of Autism Spectrum Disorders is subject to the maximum benefit amount, if any, shown on the *Schedule of Benefits*.

Diagnostic and Preoperative Testing (GR96782 11-085 02 V/A)

Diagnostic Complex Imaging Expenses

The plan covers charges made on an outpatient basis by a **physician, hospital** or a licensed imaging or radiological facility for complex imaging services to diagnose an **illness** or **injury**, including:

- C.A.T. scans;
- Magnetic Resonance Imaging (MRI);
- Nuclear medicine imaging including Positron Emission Tomography (PET) scans; and
- Any other outpatient diagnostic imaging service where the **recognized charge** exceeds \$500.

Complex Imaging Expenses for preoperative testing will be payable under this benefit.

Limitations

The plan does not cover diagnostic complex imaging expenses under this part of the plan if such imaging expenses are covered under any other part of the plan.

Outpatient Diagnostic Lab Work and Radiological Services

Covered expenses include charges for radiological services (other than diagnostic complex imaging), lab services, and pathology and other tests provided to diagnose an **illness** or **injury**. You must have definite symptoms that start, maintain or change a plan of treatment prescribed by a **physician**. The charges must be made by a **physician**, **hospital** or licensed radiological facility or lab.

Important Note

Refer to the *Schedule of Benefits* for details about any **deductible**, **coinsurance**, or benefit maximum that applies to outpatient diagnostic testing, lab and radiological services.

Outpatient Preoperative Testing

Prior to a scheduled covered surgery, **covered expenses** include charges made for tests performed by a **hospital**, **surgery center**, **physician** or licensed diagnostic laboratory provided the charges for the surgery are **covered expenses** and the tests are:

- Related to your surgery, and the surgery takes place in a **hospital** or **surgery center**;
- Completed within 14 days before your surgery;
- Performed on an outpatient basis;
- Covered if you were an inpatient in a **hospital**;
- Not repeated in or by the **hospital** or **surgery center** where the surgery will be performed; and
- Test results should appear in your medical record kept by the **hospital** or **surgery center** where the surgery is performed.

Limitations

The plan does not cover diagnostic complex imaging expenses under this part of this Plan if such imaging expenses are covered under any other part of this Plan.

- If your tests indicate that surgery should not be performed because of your physical condition, the plan will pay for the tests, however surgery will not be covered.
- If tests are done, and you cancel the surgery, benefits are paid after any applicable **deductible**.

Important Reminder

Complex Imaging testing for preoperative testing is covered under the *Complex Imaging* section. Separate cost sharing may apply. Refer to your *Schedule of Benefits* for information on cost sharing amounts for complex imaging.

Durable Medical and Surgical Equipment (DME) (GR96782 11-090 01)

Covered expenses include charges by a **DME** supplier for the rental of equipment or, in lieu of rental:

The initial purchase of **DME** if:

- Long term care is planned; and
- The equipment cannot be rented or is likely to cost less to purchase than to rent.

Repair of purchased equipment. Maintenance and repairs needed due to misuse or abuse are not covered.

The plan limits coverage to one item of equipment, for the same or similar purpose and the accessories 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.

Replacement of purchased equipment if:

- The replacement is needed because of a change in your physical condition; and
- It is likely to cost less to replace the item than to repair the existing item or rent a similar item.

Covered **durable medical equipment** includes those items covered by Medicare unless excluded in the *Exclusions* section of this *Booklet-Certificate*. We reserve the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at Our discretion.

Important Reminder

Refer to the *Schedule of Benefits* for details about **durable medical and surgical equipment deductible, coinsurance** and benefit maximums. Also refer to *Exclusions* for information about Home and Mobility exclusions.

Experimental or Investigational Treatment (GR96782 11-095 01)

Covered expenses include charges made for **experimental or investigational** drugs, devices, treatments or procedures, provided all of the following conditions are met:

- You have been diagnosed with cancer or a condition likely to cause death within one year or less;
- Standard therapies have not been effective or are inappropriate;
- We determine, based on at least two documents of medical and scientific evidence, that you would likely benefit from the treatment;
- You are enrolled in a clinical trial that meets these criteria:
- The drug, device, treatment or procedure to be investigated has been granted investigational new drug (IND) or Group c/treatment IND status;
- The clinical trial has passed independent scientific scrutiny and has been approved by an Institutional Review Board that will oversee the investigation;
- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar national organization (such as the Food & Drug Administration or the Department of Defense) and conforms to the NCI standards;
- The clinical trial is not a single institution or investigator study unless the clinical trial is performed at an NCI-designated cancer center; and
- You are treated in accordance with protocol.

Pregnancy Related Expenses (GR96782 11-100 01 V.A)

Covered expenses include charges made by a **physician** for pregnancy and childbirth services and supplies at the same level as any **illness** or **injury**. This includes prenatal visits, delivery and postnatal visits.

For inpatient care of the mother and newborn child, **covered expenses** include charges made by a **hospital** for a minimum of:

- 48 hours after a vaginal delivery; and
- 96 hours after a cesarean section.
- A shorter stay, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier.

If the mother is discharged earlier, the Plan will pay for 1 post-delivery home visit by a health care provider scheduled to occur within 24 hours of discharge. An additional visit will be covered when prescribed by the provider. This benefit is in addition to the home health maximum number of visits, if any, shown on the *Schedule of Benefits*. No copayment or coinsurance will apply for these home health care visits.

Covered expenses also include charges made by a **birthing center** as described under *Alternatives to Hospital Care*.

Postpartum Service Expenses

If the Plan includes coverage for obstetrical services, it will include covered medical expenses for inpatient care and a home visit or visits which shall be in accordance with the medical criteria outlined in the most current version, of or an official update to the “Guidelines for Perinatal Care” prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the “Standards of Obstetric-Gynecologic Services” prepared by the American College of Obstetricians and Gynecologists.

Important Note

Covered expenses also include services and supplies provided for circumcision.

Prosthetic Devices (GR96782 11-111 02 V/A)

Covered expenses include charges made for medically necessary prosthetic devices, including their components, fitting, repair and replacements, and special appliances, if the device or appliance improves or restores body part function that has been lost or damaged by **illness, injury** or congenital defect. **Covered expenses** also include instruction and incidental supplies needed to use a covered prosthetic device.

As used in this section, the following words have the following meanings:

“Component” means: the materials and equipment needed to ensure the comfort and functioning of a prosthetic device.

“Prosthetic Device” means: an artificial device to replace, in whole or in part, a limb.

“Limb” means: an arm, a hand, a leg, a foot or any portion of an arm, a hand, a leg or a foot.

This Plan also covers the first prosthesis, other than a limb, you need that temporarily or permanently replaces all or part of a body part lost or impaired as a result of **illness** or **injury**, or congenital defect as described in the list of covered devices below for an:

- Internal body part or organ; or
- External body part.

Covered expenses also include replacement of the first prosthesis if:

- The replacement is needed because of a change in your physical condition; or your normal growth, or the prosthesis’ wear and tear; or
- It is likely to cost less to buy a new one than to repair the existing one; or
- The existing one cannot be made serviceable.

The list of covered devices includes but is not limited to:

- A limb;
- An artificial eye;
- Eye lens;
- An external breast prostheses and the first bra made solely for use with it after a mastectomy;
- A breast implant after a mastectomy;
- Ostomy supplies, urinary catheters, and external urinary collection devices;
- Speech generating device;
- A cardiac pacemaker and pacemaker defibrillators; and
- A durable brace that is custom made for and fitted for you.

Limitations:

Unless specified above, not covered under this benefit are charges incurred for, or expenses related to:

- Services which are covered to any extent under any other part of this Plan;
- 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; or
- Trusses, corsets, and other support items; or
- The repair and replacement of any device due to neglect, misuse or abuse; or
- A prosthetic device designed primarily for an athletic purpose; or
- Any item listed in the *Prosthetic Devices Exclusions* section of this Booklet-Certificate.

Reconstructive or Cosmetic Surgery and Supplies (GR96782 11-125 01)

Covered expenses include charges made by a **physician, hospital, or surgery center** for reconstructive services and supplies, including:

- Surgery to correct the result of an accidental **injury**, provided that the surgery occurs no more than 24 months after the **injury**. For a covered child, the time period for coverage may be extended through age 18 or up to 24 months after the **injury**, whichever period is longer. **Injuries** that occur during surgical procedures or medical treatments are not considered accidental **injuries**, even if unplanned or unexpected.
- Surgical implantation or attachment of covered prosthetic devices.
- Surgery to correct a gross anatomical defect present at birth. The surgery will be covered if the defect results in severe facial disfigurement or significant functional impairment of a body part; and the purpose of the surgery is to improve function.
- Other surgery needed when the treatment of an **illness** results in significant functional impairment of a body part. The surgery must be needed to improve function.

Reconstructive Breast Surgery

Covered expenses include reconstruction of the breast on which a mastectomy was performed, including an implant and areolar reconstruction. Also included is surgery on a healthy breast to make it symmetrical with the reconstructed breast and physical therapy to treat complications of mastectomy, including lymphedema.

Important Notice

A benefit maximum may apply to reconstructive or **cosmetic** surgery services. Please refer to the *Schedule of Benefits*.

Short-Term Rehabilitation Therapy Services (GR96782 11-120 06 V.A)

Covered expenses include charges for short-term therapy services when prescribed by a **physician** as described below up to the benefit maximums listed on your *Schedule of Benefits*. The services have to be performed by:

- A licensed or certified physical, occupational or speech therapist;
- A **hospital, skilled nursing facility, or hospice facility**;
- A **home health care agency**; or
- A **physician**.

Charges for the following short term rehabilitation expenses are covered:

Cardiac and Pulmonary Rehabilitation Benefits.

Coverage is subject to the limits, if any, shown on the *Schedule of Benefits*. Inpatient rehabilitation benefits for the services listed will be paid as part of your Inpatient Hospital and Skilled Nursing Facility benefits provision in this *Booklet-Certificate*.

Cardiac Rehabilitation Benefits

- Cardiac rehabilitation is the process of restoring and maintaining the physiological, psychological, social and vocational capabilities of patients with heart disease. Cardiac rehabilitation benefits are available as part of an inpatient **hospital stay**. A limited course of outpatient cardiac rehabilitation is covered when following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction. This Plan will cover charges in accordance with a treatment plan as determined by your risk level when recommended by a **physician**. This course of treatment is limited to a maximum of 36 sessions in a 12 week period.

Pulmonary Rehabilitation Benefits

- Pulmonary rehabilitation benefits are available as part of an inpatient **hospital stay**. A limited course of outpatient pulmonary rehabilitation treatment is covered for the introduction of dry or moist gases into the lungs to treat **illness** or **injury**. This course of treatment is limited to a maximum of 36 hours or a 6 week period.

Outpatient Cognitive Therapy, Physical Therapy, Occupational Therapy and Speech Therapy Rehabilitation Benefits.

Coverage is subject to the limits, if any, shown on the *Schedule of Benefits*. Inpatient rehabilitation benefits for the services listed will be paid as part of your Inpatient Hospital and Skilled Nursing Facility benefits provision in this *Booklet-Certificate*.

- Physical therapy is covered for non-chronic conditions and acute **illnesses** and **injuries**, provided the therapy is expected to significantly improve, develop or restore physical functions lost or impaired as a result of an acute **illness, injury** or surgical procedure. Physical therapy does not include educational training or services designed to develop physical function.
- Occupational therapy (except for vocational rehabilitation or employment counseling) is covered for non-chronic conditions and acute **illnesses** and **injuries**, provided the therapy is expected to significantly improve, develop or restore physical functions lost or impaired as a result of an acute **illness, injury** or surgical procedure, or to relearn skills to significantly improve independence in the activities of daily living. Occupational therapy does not include educational training or services designed to develop physical function.
- Speech therapy is covered for non-chronic conditions and acute **illnesses** and **injuries** provided the therapy is expected to restore the speech function or correct a speech impairment resulting from **illness** or **injury**; or for delays in speech function development as a result of 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 therapy associated with physical rehabilitation is covered when the cognitive deficits have been acquired as a result of neurologic impairment due to trauma, stroke, or encephalopathy, and when the therapy is part of a treatment plan intended to restore previous cognitive function.

A "visit" consists of no more than one hour of therapy. Refer to the *Schedule of Benefits* for the visit maximum that applies to the plan. **Covered expenses** include charges for two therapy visits of no more than one hour in a 24-hour period.

The therapy should follow a specific treatment plan that:

- Details the treatment, and specifies frequency and duration; and
- Provides for ongoing reviews and is renewed only if continued therapy is appropriate.

If you are **homebound**, therapy services may be provided in your home.

Important Reminder

Refer to the *Schedule of Benefits* for details about the short-term rehabilitation therapy maximum benefit.

Unless specifically covered above, not covered under this benefit are charges for:

- Therapies for the treatment of delays in development, unless resulting from acute **illness** or **injury**, or congenital defects amenable to surgical repair (such as cleft lip/palate). Examples of non-covered diagnoses include Pervasive Developmental Disorders, Down Syndrome, and Cerebral Palsy, as they are considered both developmental and/or chronic in nature. Physical therapy, occupational therapy and speech therapy services for the treatment of Autism Spectrum Disorder are not subject to the maximum benefit limits, if any shown in the *Schedule of Benefits* applicable to this coverage.
- Any services which are **covered expenses** in whole or in part under any other group plan sponsored by an employer;
- Any services unless provided in accordance with a specific treatment plan;
- Services provided during a **stay** in a **hospital, skilled nursing facility, or hospice facility except as stated above**;
- Services not performed by a **physician** or under the direct supervision of a **physician**;
- Treatment covered as part of the Spinal Manipulation Treatment. This applies whether or not benefits have been paid under the Spinal Manipulation Treatment benefit;
- Services provided by a **physician** or physical, occupational or speech therapist who resides in your home; or who is a member of your family, or a member of your spouse's family; or your domestic partner;
- Special education to instruct a person whose speech has been lost or impaired, to function without that ability. This includes lessons in sign language.

Specialized Care (GR96782 11-135 05 V.A)

Chemotherapy

Covered expenses include charges for chemotherapy treatment. Coverage levels depend on where treatment is received. In most cases, chemotherapy is covered as outpatient care. Inpatient **hospitalization** for chemotherapy is limited to the initial dose while **hospitalized** for the diagnosis of cancer and when a **hospital stay** is otherwise **medically necessary** based on your health status.

Radiation Therapy Benefits

Covered expenses include charges for the treatment of **illness** by x-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes.

Outpatient Infusion Therapy Benefits

Covered expenses include infusion therapy received from an outpatient setting including but not limited to:

- A free-standing outpatient facility;
- The outpatient department of a **hospital**; or
- A **physician** in his/her office or in your home.

The list of preferred infusion locations can be found by contacting Member Services by logging onto your secure member website at www.Innovation-Health.com or calling the number on the back of your ID card.

Certain infused medications may be covered under the **prescription drug** plan. You can access the list of **specialty care prescription drugs** by contacting Member Services or by logging onto your secure member website at www.Innovation-Health.com or calling the number on the back of your ID card to determine if coverage is under the **prescription drug** plan or this certificate.

Infusion therapy is the intravenous or continuous administration of medications or solutions that are **medically necessary** for your course of treatment. Charges for the following outpatient Infusion Therapy services and supplies are **covered expenses**:

- Pharmaceuticals when administered in connection with infusion therapy and any medical supplies, equipment and nursing services required to support the infusion therapy;
- Professional services;
- Total parenteral nutrition (TPN);
- Chemotherapy;
- Drug therapy (includes antibiotic and antivirals);
- Pain management (narcotics); and
- Hydration therapy (includes fluids, electrolytes and other additives).

Not included under this infusion therapy benefit are charges incurred for:

- Enteral nutrition;
- Blood transfusions and blood products;
- Dialysis; and
- Insulin.

Coverage is subject to the maximums, if any, shown in the *Schedule of Benefits*.

Coverage for inpatient infusion therapy is provided under the *Inpatient Hospital* and *Skilled Nursing Facility Benefits* sections of this *Booklet-Certificate*.

Benefits payable for infusion therapy will not count toward any applicable **Home Health Care** maximums.

Important Reminder

Refer to the *Schedule of Benefits* for details about any applicable **deductible**, **coinsurance** or benefit maximum that apply.

Specialty Care Prescription Drugs

Covered expenses include **specialty care prescription drugs** when they are:

- Purchased by your **provider**, and
- 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** in his/her office
 - A home care **provider** in your home
- And, listed on our **specialty care prescription drug** list as covered under this certificate.

Certain infused medications may be covered under the **prescription drug** plan. You can access the list of **specialty care prescription drugs** by contacting Member Services or by logging onto your secure member website at www.innovation-health.com or calling the number on the back of your ID card to determine if coverage is under the **prescription drug** plan or this certificate.

Diabetic Equipment, Supplies and Education (GR96782 11-135 05 VA)

Covered expenses include charges for the following services, supplies, equipment, and self-management training and educational for the treatment of insulin and non-insulin dependent diabetes, insulin and non-insulin using diabetes and elevated blood glucose levels during pregnancy:

- Insulin preparations;
- External insulin pumps
- Syringes;
- Hypodermic needles;
- Injection aids for the blind
- Test strips and tablets;
- Blood glucose monitors without special features unless required due to blindness;
- Lancets;
- Prescribed oral medications whose primary purpose is to influence blood sugar;
- Alcohol swabs;
- Injectable glucagons;
- Glucagon emergency kits;
- Self-management training provided by a licensed health care provider certified in diabetes self-management training; and
- Foot care to minimize the risk of infection, including routine foot care such as treatment of corns, calluses and care of toenails.

Treatment of Infertility (GR96782 11-135 01 VA)

Basic Infertility Expenses

Covered expenses include charges made by a **physician** to diagnose and to surgically treat the underlying medical cause of **infertility**.

Spinal Manipulation Treatment (GR96782 11-150 01 VA)

Covered expenses include charges made by a **physician** on an outpatient basis for manipulative (adjustive) treatment or other physical treatment for conditions caused by (or related to) biomechanical or nerve conduction disorders of the spine.

Your benefits are subject to the maximum shown in the *Schedule of Benefits*. However, this maximum does not apply to expenses incurred:

- During your **hospital stay**; or
- For surgery. This includes pre- and post-surgical care provided or ordered by the operating **physician**.

Bones or Joints of the Head, Neck, Face or Jaw Expenses (GR96782 11-150 01 VA)

Covered expenses include charges for diagnostic and surgical treatment involving any bone or joint of the head, neck, face or jaw if the treatment is required due to a medical condition or **injury** which prevents normal function of the joint or bone and is deemed **medically necessary** to attain functional capacity of the affected part. Treatment performed by prosthesis placed directly on the teeth is not covered.

Treatment of Cleft Lip or Palate (GR96782 11-155 01)

(Dependent Children Under Age 18 only)

Covered expenses include charges made for the treatment of a congenital cleft lip or cleft palate, or of a condition related to the cleft lip or palate, including:

- Oral surgery and facial surgery, including pre and post-operative care provided by a **physician**;
- Oral prosthesis treatment, including obturators and orthotic devices, speech and feeding appliances;
- Initial installation of dentures, whether fixed or removable, partial or full;
- Replacement of dentures by dentures or fixed partial dentures when needed because of structural changes in the mouth or jaw due to growth;
- Cleft orthodontic therapy;
- Orthodontic, otolaryngology or prosthetic treatment and management;
- Installation of crowns;
- Diagnostic services provided by a **physician** to determine the extent of loss or impairment in your speaking or hearing ability;
- Speech therapy to treat delays in speech development given by a **physician**. Such therapy is expected to overcome congenital or early acquired handicaps;
- Speech therapy provided by a **physician**, if the therapy is expected to restore or improve your ability to speak. Coverage includes speech aids and training to use the speech aids;
- Psychological assessment and counseling;
- Genetic assessment and counseling;
- Hearing aids;
- Audiological assessment, treatment and management, including surgically implanted amplification devices; and
- Physical therapy assessment and treatment.

A legally qualified audiologist or speech therapist will be deemed a **physician** for purposes of this coverage.

Unless specified above, not covered under this benefit are:

- Oral prostheses, dentures or fixed partial dentures that were ordered before your coverage became effective or ordered while you were covered, but installed or delivered more than 60 days after your coverage ended;
- Augmentative (assistive) communication systems and usage training. (These aids are used in the special education of a person whose ability to speak or hear has been impaired, including lessons in sign language.)

Transplant Services (GR-96782 11-160 02)

Covered expenses include charges incurred during a transplant occurrence. The following will be considered to be one transplant occurrence once it has been determined that you or one of your dependents may require an organ transplant. Organ means solid organ; stem cell; bone marrow; and tissue.

- Heart;
- Lung;
- Heart/Lung;
- Simultaneous Pancreas Kidney (SPK);
- Pancreas;
- Kidney;
- Liver;
- Intestine;
- Bone Marrow/Stem Cell;
- Multiple organs replaced during one transplant surgery;
- Tandem transplants (Stem Cell);
- Sequential transplants;

- Re-transplant of same organ type within 180 days of the first transplant;
- Any other single organ transplant, unless otherwise excluded under the plan.

The following will be considered to be more than one Transplant Occurrence:

- Autologous blood/bone marrow transplant followed by allogenic blood/bone marrow transplant (when not part of a tandem transplant);
- Allogenic blood/bone marrow transplant followed by an autologous blood/bone marrow transplant (when not part of a tandem transplant);
- Re-transplant after 180 days of the first transplant;
- Pancreas transplant following a kidney transplant;
- A transplant necessitated by an additional organ failure during the original transplant surgery/process;
- More than one transplant when not performed as part of a planned tandem or sequential transplant, (e.g., a liver transplant with subsequent heart transplant).

The **network** level of benefits is paid only for a treatment received at a facility designated by the plan as an **Institute of Excellence™ (IOE)** for the type of transplant being performed. Each **IOE** facility has been selected to perform only certain types of transplants.

Services obtained from a facility that is not designated as an **IOE** for the transplant being performed will be covered as **out-of-network** services and supplies, even if the facility is a **network** facility or **IOE** for other types of services.

The plan covers:

- Charges made by a **physician** or transplant team.
- Charges made by a **hospital**, outpatient facility or **physician** for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.
- Related supplies and services provided by the facility during the transplant process. These services and supplies may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; home health care expenses and home infusion services.
- Charges for activating the donor search process with national registries.
- Compatibility testing of prospective organ donors who are immediate family members. For the purpose of this coverage, an “immediate” family member is defined as a first-degree biological relative. These are your biological parents, siblings or children.
- Inpatient and outpatient expenses directly related to a transplant.

Covered transplant expenses are typically incurred during the four phases of transplant care described below. Expenses incurred for one transplant during these four phases of care will be considered one transplant occurrence.

A transplant occurrence is considered to begin at the point of evaluation for a transplant and end either 180 days from the date of the transplant; or upon the date you are discharged from the **hospital** or outpatient facility for the admission or visit(s) related to the transplant, whichever is later.

The four phases of one transplant occurrence and a summary of covered transplant expenses during each phase are:

1. Pre-transplant evaluation/screening: Includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility’s transplant program;
2. Pre-transplant/candidacy screening: Includes HLA typing/compatibility testing of prospective organ donors who are immediate family members;

3. Transplant event: Includes inpatient and outpatient services for all covered transplant-related health services and supplies provided to you and a donor during the one or more surgical procedures or medical therapies for a transplant; **prescription drugs** provided during your inpatient **stay** or outpatient visit(s), including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during your inpatient **stay** or outpatient visit(s); cadaveric and live donor organ procurement; and
4. Follow-up care: Includes all covered transplant expenses; home health care services; home infusion services; and transplant-related outpatient services rendered within 180 days from the date of the transplant event.

If you are a participant in the **IOE** program, the program will coordinate all solid organ and bone marrow transplants and other specialized care you need. Any **covered expenses** you incur from an **IOE** facility will be considered network care expenses.

Important Reminders

To ensure coverage, all transplant procedures need to be **precertified** by Us. Refer to the *How the Plan Works* section for details about **precertification**.

Refer to the *Schedule of Benefits* for details about transplant expense maximums, if applicable.

Limitations

Unless specified above, not covered under this benefit are charges incurred for:

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence;
- Services that are covered under any other part of this plan;
- Services and supplies furnished to a donor when the recipient is not covered under this plan;
- Home infusion therapy after the transplant occurrence;
- Harvesting or storage of organs, without the expectation of immediate transplantation for an existing **illness**;
- Harvesting and/or storage of bone marrow, tissue or stem cells, without the expectation of transplantation within 12 months for an existing **illness**;
- Cornea (Corneal Graft with Amniotic Membrane) or Cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by Us.

Network of Transplant Specialist Facilities

Through the **IOE** network, you will have access to a provider **network** that specializes in transplants. Benefits may vary if an **IOE** facility or non-**IOE** or **out-of-network provider** is used. The **IOE** facility must be specifically approved and designated by Us to perform the procedure you require. Each facility in the **IOE** network has been selected to perform only certain types of transplants, based on quality of care and successful clinical outcomes.

Morbid Obesity Treatment (GR96782 11-165 01 V.A)

Covered expenses include charges made by a **physician** or **hospital** for gastric bypass surgery or other such methods as may be recognized by the National Institutes of Health as effective for the long-term reversal of morbid obesity.

As used in this section:

Morbid obesity means: (i) a weight that is at least 100 pounds over or twice the ideal weight for frame, age, height, and gender as specified in the 1983 Metropolitan Life Insurance Tables; (ii) a body mass index (BMI) equal to or greater than 35 kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes; or (iii) a BMI of 40 kilograms per meter squared without such comorbidity.

“Body Mass Index” (BMI) equals weight in kilograms divided by height in meters squared.

Covered expenses are payable to the same extent as any other **illness**.

Limitations

Unless specified above, not covered under this benefit are charges incurred for:

- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications; exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including morbid obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions; except as provided in this *Booklet-Certificate*.

Treatment of Mental Disorders and Substance Abuse (GR96782 11-172 01 V4)

Treatment of Mental Disorders

Covered expenses include charges made for the treatment of **mental disorders** by **behavioral health providers**.

Important Note

Not all types of services are covered. For example, educational services and certain types of therapies are not covered. See *Health Plan Exclusions and Limits* for more information.

In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

- The treatment must be **medically necessary**;
- There is a written treatment plan prescribed and supervised by a **behavioral health provider**; and
- This Plan includes follow-up treatment.

Benefits are payable for charges incurred in a **hospital, psychiatric hospital, residential treatment facility** or **behavioral health provider's** office for the treatment of **mental disorders** as follows:

Inpatient Treatment

Covered expenses include charges for **room and board** at the **semi-private room rate**, and other services and supplies provided during your **stay** in a **hospital, psychiatric hospital** or **residential treatment facility**. Inpatient benefits are payable only if your condition requires services that are only available in an inpatient setting.

Important Reminder

Inpatient care, partial **hospitalizations** and outpatient treatment must be **precertified** by Us. Refer to *How the Plan Works* for more information about **precertification**.

Partial Confinement Treatment

Covered expenses include charges made for **partial confinement treatment** provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of a **mental disorder**. Such benefits are payable if your condition requires services that are only available in a **partial confinement treatment** setting.

Important Reminder

Inpatient care, partial **hospitalizations** and outpatient treatment must be **precertified** by Us. Refer to *How the Plan Works* for more information about **precertification**.

Outpatient Treatment

Covered expenses include charges for treatment received while not confined as a full-time inpatient in a **hospital, psychiatric hospital** or **residential treatment facility**.

The plan covers partial **hospitalization** services (more than 4 hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment. The partial **hospitalization** will only be covered if you would need inpatient care if you were not admitted to this type of facility.

Important Reminder

- Inpatient care, partial **hospitalizations** and outpatient treatment must be **precertified** by Us. Refer to *How the Plan Works* for more information about **precertification**.
- Please refer to the *Schedule of Benefits* for any **copayments/deductibles**, maximums and **Maximum Out of Pocket Limit** that may apply.

Treatment of Substance Abuse

Covered expenses include charges made for the treatment of **substance abuse** by **behavioral health providers**.

Important Note

Not all types of services are covered. For example, educational services and certain types of therapies are not covered. See *Health Plan Exclusions and Limits* for more information.

Substance Abuse

In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

- There is a program of therapy prescribed and supervised by a **behavioral health provider**.
- The program of therapy includes either:
 - A follow up program directed by a **behavioral health provider** on at least a monthly basis; or
 - Meetings at least twice a month with an organization devoted to the treatment of **substance abuse**.

Please refer to the *Schedule of Benefits* for any **deductibles**, maximums, and Maximum Out of Pocket Limit that may apply.

Inpatient Treatment

This Plan covers **room and board** at the **semi-private room rate** and other services and supplies provided during your **stay** in a **psychiatric hospital** or **residential treatment facility**, appropriately licensed by the state Department of Health or its equivalent.

Coverage includes:

- Treatment in a **hospital** for the medical complications of **substance abuse**.
- “Medical complications” include **detoxification**, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens and hepatitis.
- Treatment in a **hospital** is covered only when the **hospital** does not have a separate treatment facility section.

Important Reminder

Inpatient care, partial **hospitalizations** and outpatient treatment must be **precertified** by Us. Refer to *How the Plan Works* for more information about **precertification**.

Outpatient Treatment

Outpatient treatment includes charges for treatment received for **substance abuse** while not confined as a full-time inpatient in a **hospital, psychiatric hospital** or **residential treatment facility**.

This Plan covers partial **hospitalization** services (more than 4 hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of alcohol or drug abuse. The partial **hospitalization** will only be covered if you would need inpatient treatment if you were not admitted to this type of facility.

Important Reminder

Inpatient treatment, partial-hospitalization care and outpatient treatment must be **precertified** by Us. Refer to *How the Plan Works* for more information about **precertification**.

Partial Confinement Treatment

Covered expenses include charges made for **partial confinement treatment** provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of **substance abuse**.

Such benefits are payable if your condition requires services that are only available in a **partial confinement treatment** setting.

Important Reminders:

- Inpatient care, partial **hospitalizations** and outpatient treatment must be **precertified** by Us. Refer to *How the Plan Works* for more information about **precertification**.
- Please refer to the *Schedule of Benefits* for any **copayments/deductibles**, maximums and Maximum Out of Pocket Limit that may apply.

Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth) (GR96782 11-180 01)

Covered expenses include charges made by a **physician**, a **dentist** and **hospital** for:

- Non-surgical treatment of infections or diseases of the mouth, jaw joints or supporting tissues.

Services and supplies for treatment of, or related conditions of, the teeth, mouth, jaws, jaw joints or supporting tissues, (this includes bones, muscles, and nerves), for surgery needed to:

- Treat a fracture, dislocation, or wound.
- Cut out teeth that are partly or completely impacted in the bone of the jaw; teeth that will not erupt through the gum; other teeth that cannot be removed without cutting into bone; the roots of a tooth without removing the entire tooth; cysts, tumors, or other diseased tissues.
- Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement or repair of teeth.
- Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.

Hospital services and supplies received for a **stay** required because of your condition.

Dental work, surgery and **orthodontic treatment** needed to remove, repair, restore or reposition:

- (a) Natural teeth damaged, lost, or removed; or
- (b) Other body tissues of the mouth fractured or cut

due to **injury**.

Any such teeth must have been free from decay or in good repair, and are firmly attached to the jaw bone at the time of the **injury**.

The treatment must be completed in the Calendar Year of the **accident** or in the next Calendar Year.

If crowns, dentures, bridges, or in-mouth appliances are installed due to **injury**, **covered expenses** only include charges for:

- The first denture or fixed bridgework to replace lost teeth;
- The first crown needed to repair each damaged tooth; and
- An in-mouth appliance used in the first course of **orthodontic treatment** after the **injury**.

Nutritional Supplement Services *(GR96782 11-137 01 VA)*

Covered expenses include charges incurred for nutritional supplements (formulas) as **medically necessary** for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria as administered under the direction of a **physician**.

Nutritional Supplement Services shall be exempt from any **deductible** provision.

Other Services *(GR-96782 11-195-01-VA)*

General Anesthesia for Dental Care

Covered medical expenses include general anesthesia and associated **hospital** or ambulatory facility charges in conjunction with dental care provided to a covered person, if the person is determined by a licensed **dentist** in consultation with the person's **physician** to require these services to effectively and safely provide dental care; and

- i. is under 5 years of age;
- ii. is severely disabled; or
- iii. has a medical condition that requires admission to a **hospital** or outpatient **surgery center** and general anesthesia for dental care treatment.

Coverage is not provided for dental services associated with general anesthesia and associated **hospital** or ambulatory facility charges, except as otherwise provided in this Plan.

Infant Hearing Screening Expenses

Covered medical expenses include charges for infant hearing screenings and all necessary audiological examinations for newborn children that are provided pursuant to the Virginia Hearing Impairment Identification and Monitoring System and include the use of any technology approved by the United States Food and Drug Administration, and as recommended by the national Joint Committee on Infant Hearing in its most current position statement addressing early hearing detection and intervention programs. Coverage includes a follow-up audiological examination, recommended by a **physician** or audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss, for those infants whose hearing screenings indicated the need for a diagnostic audiological examination.

Bones or Joints of the Head, Neck, Face or Jaw Expenses

Covered medical expenses include charges for diagnostic and surgical treatment involving any bone or joint of the head, neck, face or jaw if the treatment is required due to a medical condition or **injury** which prevents normal function of the joint or bone and is deemed **medically necessary** to attain functional capacity of the affected part. Treatment performed by prosthesis placed directly on the teeth is not covered

Blood Products and Blood Infusion Equipment Expenses

Covered medical expenses include charges for blood products and blood infusion equipment for covered persons diagnosed with hemophilia or other congenital bleeding disorders.

Mastectomy and Hysterectomy Expenses

Covered medical expenses following a mastectomy for the treatment of breast cancer include charges for:

- up to 48-hours of inpatient care in a **hospital** following a radical or modified mastectomy;
- up to 24-hours of inpatient care in a **hospital** following a total mastectomy or partial mastectomy with lymph node dissection.

Covered medical expenses following a hysterectomy include charges for:

- a minimum stay in a **hospital** of not less than 23-hours following a laparoscopy-assisted vaginal hysterectomy;
- a minimum stay in a **hospital** of not less than 48-hours following a vaginal hysterectomy; or
- a shorter **hospital** stay, if the attending provider, in consultation with the covered person, determines that a shorter length of stay is appropriate.

Treatment of Lymphedema

Covered medical expenses include charges for equipment, supplies, complex decongestive therapy, and outpatient self-management training and education for the treatment of lymphedema, when provided by a provider legally authorized to provide such items under law.

Early Intervention Services

Covered medical expenses include charges for speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices for a covered person if:

- They are between the ages of birth and 3 years;
- They are certified by the Department of Behavioral Health and Developmental Services as eligible for the services under Part H of the Individuals with Disabilities Education Act; and
- The services are designed to attain or retain the capacity to function age-appropriately within their environment.

The benefit for these services is limited to \$5,000 per covered person per Calendar Year.

Cancer Clinical Trial Expenses

Covered medical expenses include coverage for "Patient Costs" incurred by a covered person participating in clinical trials for treatment studies on cancer.

"Patient Cost" is defined as the cost of a **medically necessary** health care service incurred for treatment of a covered person for purposes of a clinical trial

NOTE: This definition excludes the cost of: (a) an investigational drug or device; (b) non-health services required as a result of treatment received in a clinical trial; (c) managing research associated with the clinical trial; and (d) services or items that would be excluded from coverage under the patient's policy, plan or contract for noninvestigational treatment.

Coverage of patient costs will be provided if:

- the treatment or studies are part of a Phase II-IV clinical trial for cancer;
- the treatment is being provided in a clinical trial approved by the National Cancer Institute (NCI), an NCI cooperative group or center, the FDA as part of an investigational new drug application, the Federal Department of Veterans Affairs, or an institutional review board which has a multiple project assurance contract approved by the office of protection from research risks of the National Cancer Institute;
- the treating facility and personnel have the expertise and capability to render the treatment as a result of their experience, training and volume of patients;

- there is no clearly superior, non-investigational treatment alternative; and
- available clinical or pre-clinical data provide a reasonable expectation that the treatment will be at least as effective as the non-investigational alternative.

The above coverage may be provided on a case-by-case basis if treatment is being provided in a Phase I clinical trial for cancer.

Benefits are payable on the same basis as any other **illness**.

Medical Plan Exclusions (GR-96782 28-015 010 V/A)

Not every medical service or supply is covered by the plan, even if prescribed, recommended, or approved by your **physician** or **dentist**. The plan covers only those services and supplies that are **medically necessary** and included in the *What the Plan Covers* section.

Important Note:

You have medical and **prescription drug** insurance coverage. The exclusions listed below apply to all coverage under your plan. Additional exclusions apply to specific **prescription drug** coverage. Those additional exclusions are listed separately under the *What The Plan Covers* section for each of these benefits.

Charges made for the following are not covered except to the extent listed under the *What the Plan Covers* section or by amendment attached to this *Booklet-Certificate* unless required to be covered under by state or federal law and regulations.

Acupuncture, acupressure and acupuncture therapy, except as provided in the *What the Plan Covers* section.

Allergy: Specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkel method), cytotoxicity testing (Bryan's Test) treatment of non-specific candida sensitivity, and urine autoinjections.

Any charges in excess of the benefit, dollar, day, visit or supply limits stated in this *Booklet-Certificate*.

Any non-emergency charges incurred outside of the United States if you traveled to such location to obtain medical services, **prescription drugs**, or supplies, even if otherwise covered under this *Booklet-Certificate*, or the purchase of such **prescription drugs** or supplies are unavailable or illegal in the United States; or the purchase of such **prescription drugs** or supplies outside the United States is considered illegal.

Applied Behavioral Analysis, the LEAP, TEACCH, Denver and Rutgers programs.

Behavioral Health Services:

- Alcoholism or drug abuse rehabilitation treatment on an inpatient or outpatient basis, except to the extent coverage for **detoxification** or treatment of alcoholism and drug abuse is specifically provided in the *What the Medical Plan Covers* Section.
- Treatment of a covered health care provider who specializes in the mental health care field and who receives treatment as a part of their training in that field.
- Treatment of impulse control disorders such as pathological gambling, kleptomania, pedophilia, caffeine or nicotine use.
- Treatment of antisocial personality disorder.
- Treatment in wilderness programs or other similar programs.
- Treatment of an intellectual disability or physical handicap, defects, and deficiencies. This exclusion does not apply to mental health services or to medical treatment of an intellectual disability or physical handicap in accordance with the benefits provided in the *What the Plan Covers* section of this *Booklet-Certificate*.

Blood, blood plasma, synthetic blood, blood derivatives or substitutes, including but not limited to, the provision of blood, other than blood derived clotting factors. Any related services including processing, storage or replacement costs, and the services of blood donors, apheresis or plasmapheresis are not covered. For autologous blood donations, only administration and processing costs are covered.

Charges for a service or supply furnished by a **network provider** in excess of the **negotiated charge**.

Charges for a service of supply furnished by an **out-of-network provider** in excess of the **recognized charge**.

Charges submitted for services that are not rendered, or rendered to a person not eligible for coverage under the plan.

Charges submitted for services by an unlicensed **hospital, physician** or other provider or not within the scope of the provider's license.

Contraception, except as specifically described in the *What the Plan Covers* Section:

- Over the counter contraceptive supplies including but not limited to condoms, contraceptive foams, jellies and ointments.

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 whether or not for psychological or emotional reasons except as specifically described under *Reconstructive Services* and *Specialized Care* sections of the *What the Plan Covers* section including:

- Face lifts, body lifts, tummy tucks, liposuctions, removal of excess skin, removal or reduction of non-malignant moles, blemishes, varicose veins, cosmetic eyelid surgery and other surgical procedures;
- Chemical peels, dermabrasion, laser or light treatments, bleaching, creams, ointments or other treatments or supplies to alter the appearance or texture of the skin;
- Insertion or removal of any implant that alters the appearance of the body (such as breast or chin implants);
- Removal of tattoos;
- Repair of piercings and other voluntary body modifications, including removal of injected or implanted substances or devices;
- Surgery to correct Gynecomastia;
- Breast augmentation; and
- Otoplasty.

Counseling: Services and treatment for marriage, religious, family, career, social adjustment, pastoral, or financial counselor except as specifically described in the *What the Plan Covers* section.

Court ordered services, including those required as a condition of parole or release.

Custodial Care

Dental Services: Except as specifically described in the *What the Plan Covers* section, any treatment, services or supplies related to the care, filling, removal or replacement of teeth and the treatment of **injuries** and diseases of the teeth, gums, and other structures supporting the teeth. This includes but is not limited to:

- services of **dentists**, oral surgeons, dental hygienists, and orthodontists including apicoectomy (dental root resection), root canal treatment, soft tissue impactions, treatment of periodontal disease, alveolectomy, augmentation and vestibuloplasty and fluoride and other substances to protect, clean or alter the appearance of teeth;
- dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth; and
- non-surgical treatments to alter bite or the alignment or operation of the jaw, including treatment of malocclusion or devices to alter bite or alignment.

This exclusion does not include removal of bony impacted teeth, bone fractures, removal of tumors and odontogenic cysts.

Disposable outpatient supplies: Any outpatient disposable supply or device, including sheaths, bags, elastic garments, support hose, bandages, bedpans, syringes, blood or urine testing supplies, and other home test kits; and splints, neck braces, compresses, and other devices not intended for reuse by another patient.

Drugs, medications and supplies (except as specifically described in the *What the Plan Covers* section) including:

- Over-the-counter drugs, biological or chemical preparations and supplies that may be obtained without a **prescription** including vitamins;
- Any services related to the dispensing, injection or application of a drug;
- Any **prescription drug** purchased illegally outside the United States, even if otherwise covered under this plan within the United States;
- Immunizations related to travel or work;
- Needles, syringes and other injectable aids, except as covered for diabetic supplies;
- Drugs related to the treatment of non-covered expenses;
- Performance enhancing steroids;
- Injectable drugs if an alternative oral drug is available;
- Outpatient **prescription drugs**;
- Self-injectable **prescription drugs** and medications;
- Any **prescription drugs**, injectibles, or medications or supplies provided by the policyholder or through a third party vendor contract with the policyholder;
- Any expenses for **prescription drugs** and supplies covered under Our managed prescription plan will not be covered under this medical expense plan; and
- Charges for any prescription drug for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy.

Educational services:

- Any services or supplies related to education, training or retraining services or testing, including: special education, remedial education, job training and job hardening programs;
- Evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental, learning and communication disorders, behavioral disorders, (including pervasive developmental disorders) training or cognitive rehabilitation, regardless of the underlying cause; and
- Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and delays in developing skills.

Examinations:

- Any health examinations required:
 - by a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement;
 - by any law of a government;
 - for securing insurance, school admissions or professional or other licenses;
 - to travel;
 - to attend a school, camp, or sporting event or participate in a sport or other recreational activity; and

Any special medical reports not directly related to treatment except when provided as part of a covered service.

Routine physical exams, routine eye exams, routine dental exams, routine hearing exams and other preventive services and supplies, except as specifically provided in the *What the Plan Covers* section.

Experimental or investigational drugs, devices, treatments or procedures, except as described in the *What the Plan Covers* section.

Facility charges for care services or supplies provided in:

- rest homes;
- assisted living facilities;
- similar institutions serving as an individual's primary residence or providing primarily custodial or rest care;
- health resorts;
- spas, sanitariums; or
- infirmaries at schools, colleges, or camps.

Food and nutritional items: Any food item, including infant formulas, nutritional supplements, vitamins, including **prescription** vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition.

Foot care: Except as specifically covered for diabetics, any services, supplies, or devices to improve comfort or appearance of toes, feet or ankles, including:

- treatment of calluses, bunions, toenails, hammer-toes, subluxations, fallen arches, weak feet, chronic foot pain or conditions caused by routine activities such as walking, running, working or wearing shoes; and
- Shoes (including orthopedic shoes), orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies, even if required following a covered treatment of an **illness** or **injury**.

Growth/Height: Any treatment, device, drug, service or supply to increase or decrease height or alter the rate of growth, including surgical procedures, devices to stimulate growth and growth hormones.

Hearing:

- Any hearing service or supply that does not meet professionally accepted standards;
- Hearing exams given during a **stay** in a **hospital** or other facility; and
- Any tests, appliances, and devices for the improvement of hearing including aids, hearing aids and amplifiers, or to enhance other forms of communication to compensate for hearing loss or devices that simulate speech.

Home and mobility: Any addition or alteration to a home, workplace or other environment, or vehicle and any related equipment or device, such as:

- Purchase or rental of exercise equipment, air purifiers, central or unit air conditioners, water purifiers, waterbeds, and swimming pools;
- Exercise and training devices, whirlpools, portable whirlpool pumps, sauna baths, or massage devices;
- Equipment or supplies to aid sleeping or sitting, including electric beds, water beds, pillows, sheets, blankets, warming or cooling devices, bed tables and reclining chairs;
- Equipment installed in your home, workplace or other environment, including but not limited to stair-glides, elevators, wheelchair ramps, or equipment to alter air quality, humidity or temperature;
- Other additions or alterations to your home, workplace or other environment, including room additions, changes in cabinets, countertops, doorways, lighting, wiring, furniture, communication aids, wireless alert systems, or home monitoring;
- Services and supplies furnished mainly to provide a surrounding free from exposure that can worsen your **illness** or **injury**;
- Removal from your home, worksite or other environment of carpeting, hypo-allergenic pillows, mattresses, paint, mold, asbestos, fiberglass, dust, pet dander, pests or other potential sources of allergies or **illness**; and
- Transportation devices, including stair-climbing wheelchairs, personal transporters, bicycles, automobiles, vans or trucks, or alterations to any vehicle or transportation device.

Home births: Any services and supplies related to births occurring in the home or in a place not licensed to perform deliveries.

Infertility: except as specifically described in the *What the Plan Covers* Section, any services, treatments, procedures or supplies that are designed to enhance fertility or the likelihood of conception, including but not limited to:

- Drugs related to the treatment of non-covered benefits;
- Injectable infertility medications, including but not limited to menotropins, hCG, GnRH agonists, and IVIG;
- Artificial Insemination;
- Any advanced reproductive technology (“ART”) procedures or services related to such procedures, including but not limited to in vitro fertilization (“IVF”), gamete intra-fallopian transfer (“GIFT”), zygote intra-fallopian transfer (“ZIFT”), and intra-cytoplasmic sperm injection (“ICSI”); Artificial Insemination for covered females attempting to become pregnant who are not infertile as defined by the plan;
- Infertility services for couples in which 1 of the partners has had a previous sterilization procedure, with or without surgical reversal;
- Procedures, services and supplies to reverse voluntary sterilization;
- Infertility services for females with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle;
- The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers or surrogacy; donor egg retrieval or fees associated with donor egg programs, including but not limited to fees for laboratory tests;
- Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, **hospital**, ultrasounds, laboratory tests, etc.); any charges associated with a frozen embryo or egg transfer, including but not limited to thawing charges;
- Home ovulation prediction kits or home pregnancy tests;
- Any charges associated with care required to obtain ART Services (e.g., office, **hospital**, ultrasounds, laboratory tests); and any charges associated with obtaining sperm for any ART procedures; and
- Ovulation induction and intrauterine insemination services if you are not infertile.

Maintenance Care.

Medicare: Payment for that portion of the charge for which Medicare or another party is the primary payer.

Miscellaneous charges for services or supplies including:

- Annual or other charges to be in a **physician's** practice;
- Charges to have preferred access to a **physician's** services such as boutique or concierge **physician** practices;
- Cancelled or missed appointment charges or charges to complete claim forms;
- Charges the recipient has no legal obligation to pay; or the charges would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including:
 - Care in charitable institutions;
 - Care for conditions related to current or previous military service;
 - Care while in the custody of a governmental authority;
 - Any care a public **hospital** or other facility is required to provide; or
 - Any care in a **hospital** or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws.

Nursing and home health aide services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities).

Non-**medically necessary** services, including but not limited to, those treatments, services, **prescription drugs** and supplies which are not **medically necessary**, as determined by Us, for the diagnosis and treatment of **illness, injury**, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended or approved by your **physician** or **dentist**.

Personal comfort and convenience items: Any service or supply primarily for your convenience and personal comfort or that of a third party, including:

- telephone, television, internet, barber or beauty service or other guest services;
- housekeeping, cooking, cleaning, shopping, monitoring, security or other home services; and
- travel, transportation, or living expenses, rest cures, recreational or diversional therapy.

Private duty nursing during your **stay** in a **hospital**, and outpatient private duty nursing services. Skilled nursing care is covered as specifically described in the *What the Plan Covers* section in accordance with a home health treatment plan approved by Us.

Prosthetics or prosthetic devices unless specifically covered under *What the Plan Covers* Section.

Sex change: Any treatment, drug, service or supply related to changing sex or sexual characteristics, including:

- Surgical procedures to alter the appearance or function of the body;
- Hormones and hormone therapy;
- Prosthetic devices; and
- Medical or psychological counseling.

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

Services of a resident **physician** or intern rendered in that capacity.

Services provided where there is no evidence of pathology, dysfunction, or disease; except as specifically provided in connection with covered routine care and cancer screenings.

Sexual dysfunction/enhancement: Any treatment, drug, service or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:

- Surgery, drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ; and
- Sex therapy, sex counseling, marriage counseling or other counseling or advisory services.

Tobacco Use: 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 counseling, hypnosis and other therapies, medications, nicotine patches and gum except as specifically described in the *What the Plan Covers* section.

Services, including those related to pregnancy, rendered before the effective date or after the termination of coverage, unless coverage is continued under the *Continuation of Coverage* section of this *Booklet-Certificate*.

Services that are not covered under this *Booklet-Certificate* unless required to be covered under by state or federal law and regulations.

Services and supplies provided in connection with treatment or care that is not covered under the plan.

Speech therapy for treatment of delays in speech development, except as specifically provided in the *What the Plan Covers* section. For example, the plan does not cover therapy when it is used to improve speech skills that have not fully developed.

Spinal manipulation to correct a skeletal problem or subluxation.

Strength and performance: Services, devices and supplies to enhance strength, physical condition, endurance or physical performance, including:

- Exercise equipment, memberships in health or fitness clubs, training, advice, or coaching;
- Drugs or preparations to enhance strength, performance, or endurance; and
- Treatments, services and supplies to treat **illnesses, injuries** or disabilities related to the use of performance-enhancing drugs or preparations.

Therapies for the treatment of delays in development, unless resulting from acute **illness** or **injury**, or congenital defects amenable to surgical repair (such as cleft lip/palate), are not covered except as specifically described in the *What the Plan Covers* section. Examples of non-covered diagnoses include Pervasive Developmental Disorders (including Autism), Down syndrome, and Cerebral Palsy, as they are considered both developmental and/or chronic in nature.

Therapies and tests: Any of the following treatments or procedures:

- Aromatherapy;
- Bio-feedback and bioenergetic therapy;
- Carbon dioxide therapy;
- Chelation therapy (except for heavy metal poisoning);
- Computer-aided tomography (CAT) scanning of the entire body;
- Educational therapy;
- Gastric irrigation;
- Hair analysis;
- Hyperbaric therapy, except for the treatment of decompression or to promote healing of wounds;
- Hypnosis, and hypnotherapy, except when performed by a **physician** as a form of anesthesia in connection with covered surgery;
- Lovaas therapy;
- Massage therapy;

- Megavitamin therapy;
- Primal therapy;
- Psychodrama;
- Purging;
- Recreational therapy;
- Rolfing;
- Sensory or auditory integration therapy;
- Sleep therapy;
- Thermograms and thermography.

Transplant Related Services: The transplant coverage does not include charges for:

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence;
- Services and supplies furnished to a donor when the recipient is not a covered person;
- Home infusion therapy after the transplant occurrence;
- Harvesting and/or storage of organs, without the expectation of immediate transplantation for an existing **illness**;
- Harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing **illness**;
- Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise **precertified** by Us.

Transportation costs, including **ambulance** services for routine transportation to receive outpatient or inpatient services, except as described in *What the Plan Covers* section.

Vision-related services and supplies, except as described in the *What the Plan Covers* section. The plan does not cover:

- Special supplies such as non-**prescription** sunglasses and subnormal vision aids;
- Vision service or supply which does not meet professionally accepted standards;
- Eye exams during your **stay** in a **hospital** or other facility for health care;
- Eye exams for contact lenses or their fitting;
- Eyeglasses or duplicate or spare eyeglasses or lenses or frames;
- Replacement of lenses or frames that are lost or stolen or broken;
- Acuity tests;
- Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures;
- Services to treat errors of refraction.

Weight: Any treatment, drug service or supply intended to decrease or increase body weight, control weight or treat obesity, including **morbid obesity**, regardless of the existence of comorbid conditions; except as provided by this Booklet-Certificate, including but not limited to:

- Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric surgery; surgical procedures medical treatments, weight control/loss programs and other services and supplies that are 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 or food supplements, appetite suppressants and other medications;
- Counseling, coaching, training, hypnosis or other forms of therapy; and
- Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement.

Work related: Any **illness** or **injury** related to employment or self-employment including any **illness** or **injury** that arises out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the services or supplies. Sources of coverage or reimbursement may include your employer, workers' compensation, or an occupational illness or similar program under local, state or federal law. A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. If you are also covered under a workers' compensation law or similar law, and submit proof that you are not covered for a particular illness or **injury** under such law, that illness or **injury** will be considered "non-occupational" regardless of cause.

Your Pharmacy Benefit (GR-96782 12-005 06 V.4)

How the Pharmacy Plan Works

It is important that you have the information and useful resources to help you get the most out of your **prescription drug** plan. This *Booklet-Certificate* explains:

- Definitions you need to know;
- How to access **network pharmacies** and procedures you need to follow;
- What **prescription drug** expenses are covered and what limits may apply;
- What **prescription drug** expenses are not covered by the plan;
- How you share the cost of your covered **prescription drug** expenses; and
- Other important information such as eligibility, complaints and appeals, termination, and general administration of the plan.

A few important notes to consider before moving forward:

- Unless otherwise indicated, “you” refers to you and your covered dependents.
- Your **prescription drug** plan pays benefits only for **prescription drug** expenses described in this Booklet-Certificate as covered expenses that are **medically necessary**.
- This Booklet-Certificate applies to coverage only and does not restrict your ability to receive **prescription drugs** that are not or might not be covered benefits under this **prescription drug** plan.
- Store this Booklet-Certificate in a safe place for future reference.

Important Notes:

- The plan does not cover all **prescription drugs**, medications and supplies. Refer to the *Prescription Drug Limitations* section below and the *Exclusions* section of this *Booklet-Certificate*.
- **Covered expenses** are subject to cost sharing requirements as described in the *Cost Sharing* section below and the *Schedule of Benefits*.
- **Self-injectable drugs** and **specialty care drugs** will only be covered when obtained through a **specialty pharmacy network**.
- Your **prescription drug** coverage is called a direct pay plan for **out-of-network pharmacy** benefits. With a direct pay plan you pay the **pharmacy** for the entire cost of your **prescription drug** then request reimbursement from Us for **covered expenses**.

Getting Started: Common Terms (GR-96782 08-010 04)

You will find the terms below used throughout this *Booklet-Certificate*. They are described within the sections that follow, and you can also refer to the *Glossary* at the back of this document for helpful definitions. Words in bold print throughout the document are defined in the *Glossary*.

Brand-Name Prescription Drug is a **prescription drug** with a proprietary name assigned to it by the manufacturer and so indicated by Medispan or any other similar publication designated by Us.

Generic Prescription Drug is a **prescription drug**, whether identified by its chemical, proprietary, or non-proprietary name, that is accepted by the U.S. Food and Drug Administration as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient. These drugs are identified by Medispan or any other publication designated by Us.

Network pharmacy is a description of a retail, **mail order** or **specialty pharmacy** that has entered into a contractual agreement with Us, an affiliate, or a third party vendor, for the provision of **covered services** to you and

your covered dependents. The appropriate **pharmacy** type may also be substituted for the word **pharmacy**. (E.g. **network retail pharmacy, network mail order pharmacy or specialty pharmacy network**).

Non-Preferred Drug (Non-Formulary) is a **brand-name prescription drug** or **generic prescription drug** that does not appear on the **preferred drug guide**.

Out-of-network pharmacy is a description of a **pharmacy** that has not contracted with Us, an affiliate, or a third party vendor, and does not participate in the **pharmacy network**.

Preferred Drug (Formulary) is a **brand-name prescription drug** or **generic prescription drug** that appears on the **preferred drug guide**.

Preferred Drug Guide is a listing of **prescription drugs** established by Us or an affiliate, which includes both **brand-name prescription drugs** and **generic prescription drugs**. This list is subject to periodic review and modification by Us. A copy of the **preferred drug guide** will be available upon your request or may be accessed on Our website at www.aetnaspecialtyrx.com.

Prescription Drug is a drug, biological, or compounded **prescription** which, by State or Federal Law, may be dispensed only by **prescription** and which is required by Federal Law to be labeled “Caution: Federal Law prohibits dispensing without prescription.” This includes an injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include insulin.

Provider is any recognized health care professional, **pharmacy** or facility providing services with the scope of their license.

Self-injectable Drug(s) are **prescription drugs** that are intended to be self-administered by injection to a specific part of the body to treat certain chronic medical conditions.

Specialty Pharmacy Network is a network of **pharmacies** designated to fill **self-injectable drug prescriptions**.

Accessing Pharmacies and Benefits (GR-96782 12-015 07 V/A)

This plan provides access to **covered benefits** through a network of **pharmacies**, vendors or suppliers. We have contracted for these **network pharmacies** to provide **prescription drugs** and other supplies to you.

Obtaining your benefits through **network pharmacies** has many advantages. Your out-of-pocket costs may vary between **network** and **out-of-network** benefits. Benefits and cost sharing may also vary by the type of **network pharmacy** where you obtain your **prescription drug** and whether or not you purchase a **brand-name** or **generic drug**. **Network pharmacies** include retail, **mail order** and specialty **pharmacies**.

Accessing Network Pharmacies and Benefits (GR-96782 12-015 07 V/A)

You may select a **network pharmacy** from Our on-line provider directory which can be found at www.innovation-health.com. You can search Our online **directory**, DocFind®, for names and locations of **network pharmacies**. If you cannot locate a **network pharmacy** in your area, call Member Services at the number on your ID card.

You must present your ID card to the **network pharmacy** every time you get a **prescription** filled to be eligible for **network** benefits. The **network pharmacy** will calculate your claim online. You will pay any **deductible, copayment** or **coinsurance** directly to the **network pharmacy**. You do not have to complete or submit claim forms. The **network pharmacy** will take care of claim submission.

Emergency Prescriptions (GR-96782 12-015 07 V/A)

When you need a **prescription** filled in an emergency or urgent care situation, or when you are traveling, you can obtain network pharmacy benefits by filling your **prescription** at any **network pharmacy**. The **network pharmacy** will fill your **prescription** and only charge you your plan's cost sharing amount. If you access an **out-of-network pharmacy** you will pay the full cost of the **prescription** and will need to file a claim for reimbursement. You will be reimbursed for your **covered expenses** up to the cost of the **prescription** less your plan's cost sharing for **network** benefits.

Availability of Providers

We cannot guarantee the availability or continued network participation of a particular **pharmacy**. Either We or any **network pharmacy** may terminate the **provider** contract.

Cost Sharing for Network Benefits

You share in the cost of your benefits. Cost Sharing amounts and provisions are described in the Schedule of Benefits.

- You will be responsible for the **copayment** for each **prescription** or refill as specified in the *Schedule of Benefits*. The **copayment** is payable directly to the **network pharmacy** at the time the **prescription** is dispensed.
- After you pay the applicable **copayment**, you will be responsible for any applicable **coinsurance** for **covered expenses** that you incur. Your **coinsurance** amount is determined by applying the applicable **coinsurance** percentage to the **negotiated charge** if the **prescription** is filled at a **network pharmacy**. When you obtain your **prescription drugs** through a **network pharmacy**, you will not be subject to balance billing.

When You Use an Out-of-Network Pharmacy (GR-96782 12-020 01)

You can directly access an **out-of-network pharmacy** to obtain covered outpatient **prescription drugs**.

You will pay the **pharmacy** for your **prescription drugs** at the time of purchase and submit a claim form to receive reimbursement from the plan. You are responsible for completing and submitting claim forms for reimbursement of **covered expenses** you paid directly to an **out-of-network pharmacy**. We will reimburse you for a **covered expense** up to the **recognized charge**, less any cost sharing required by you.

Cost Sharing for Out-of-Network Benefits

You share in the cost of your benefits. Cost Sharing amounts and provisions are described in the Schedule of Benefits.

- You will be responsible for any applicable **coinsurance** for **covered expenses** that you incur. Your **coinsurance** share is based on the **recognized charge**. If the **out-of-network pharmacy** charges more than the **recognized charge**, you will be responsible for any expenses above the **recognized charge**.

Pharmacy Benefit (GR-96782 13-006 02 V/A)

What the Plan Covers

The plan covers charges for **medically necessary** outpatient **prescription drugs** for the treatment of an **illness** or **injury**, subject to the *Pharmacy Drug Limitations* section below and the *Exclusions* section of the *Booklet-Certificate*. **Prescriptions** must be written by a **prescriber** licensed to prescribe federal legend **prescription drugs**.

Your prescription drug benefit coverage is based on Our **preferred drug list**. Your out-of-pocket expenses may be higher if your **physician** prescribes a covered **prescription drug** not appearing on the **preferred drug list**.

Generic prescription drugs may be substituted by your pharmacist for **brand-name prescription drugs**. You may minimize your out-of-pocket expenses by selecting a **generic prescription drug** when available.

Coverage of **prescription drugs** may, in Our sole discretion, be subject to **precertification**, **step therapy** or other requirements or limitations of Ours. **Prescription drugs** covered by this plan are subject to drug and narcotic utilization review by Us, your **provider** and/or your **network pharmacy**. This may include limiting access of **prescription drugs prescribed** by a specific **provider**. Such limitation may be enforced in the event that We identify an unusual pattern of claims for **covered expenses**.

Coverage for **prescription drugs** and supplies is limited to the supply limits as described below.

Retail Pharmacy Benefits

Outpatient **prescription drugs** are covered when dispensed by a **network retail pharmacy**. Each **prescription** is limited to a maximum 30 day supply when filled at a **network retail pharmacy**. **Prescriptions** for more than a 30 day supply are not eligible for coverage when dispensed by a **network retail pharmacy**.

Mail Order Pharmacy Benefits *(GR-96782 13-007 03 VA)*

Outpatient **prescription drugs** are covered when dispensed by a **network mail order pharmacy**. Each **prescription** is limited to a maximum 90 day supply. **Prescriptions** less than a 30 day supply or more than a 90 day supply are not eligible for coverage when dispensed by a **network mail order pharmacy**.

Network Benefits for Specialty Care Drugs *(GR-96782 13-009 03 VA)*

Specialty care drugs are covered at the network level of benefits only when dispensed through a retail **network pharmacy** or Our **specialty pharmacy network**. **Specialty care drugs** often include typically high-cost drugs that require special handling, special storage or monitoring and include but are not limited to oral, topical, inhaled and injected routes of administration. Refer to Our website, www.Innovation-Health.com to review the list of **specialty care drugs** required to be dispensed through a retail **network pharmacy** or Our **specialty pharmacy network pharmacy**. The list may be updated from time to time.

The initial prescription for **specialty care drugs** must be filled at a **network retail pharmacy** or at Our **specialty pharmacy network**.

You are required to obtain **specialty care drugs** at Our **specialty pharmacy network** for all **prescription drug** refills after the initial fill.

Other Covered Expenses

The following **prescription drugs**, medications and supplies are also **covered expenses** under this coverage.

Off-Label Use

FDA approved **prescription drugs** may be covered when the off-label use of the drug has not been approved by the FDA for that indication. The drug must be recognized for treatment of the indication in one of the standard compendia (the United States Pharmacopoeia Drug Information or the American Hospital Formulary Service Drug Information) or, the safety and effectiveness of use for this indication has been adequately demonstrated by at least one study published in a nationally recognized peer review journal.

FDA approved **prescription drugs** also may be covered when used in the treatment of cancer pain on the basis that the dosage is in excess of the recommended dosage of the pain-relieving agent, if the prescription in excess of the recommended dosage has been prescribed in compliance with applicable law for a patient with intractable cancer pain.

Coverage of off label use of these drugs may, in Our sole discretion, be subject to **precertification**, **step-therapy** or other requirements or limitations.

Diabetic Supplies (GR-96782 13-012 02 V/A)

Covered expenses include but are not limited to the following diabetic supplies upon **prescription** by a **prescriber**:

- Diabetic needles and syringes.
- Test strips for glucose monitoring and/or visual reading.
- Diabetic test agents.
- Lancets/lancing devices.
- Injection aids for the blind.
- Alcohol swabs.

(GR-96782 13-014 01 V/A)

Contraceptives. Covered expenses include charges made by a network **pharmacy** for:

- Female contraceptives that are **generic prescription drugs** and **brand-name prescription drugs**. The **prescription** must be submitted to the pharmacist for processing.
- Female contraceptive devices and related services and supplies, when prescribed in writing by a **physician**.
- FDA-approved female over-the-counter (OTC) contraceptive methods that are prescribed by your **physician**. The **prescription** must be submitted to the pharmacist for processing. These items are limited to one per day and a 30 day supply per **prescription**.

Refer to the *Copay and Deductible Waiver* section of your *Schedule of Benefits*.

Important Notes:

1. The Copay and Deductible Waiver is limited to contraceptives that are **generic prescription drugs** or devices.
2. The Copay and Deductible Waiver does not apply to contraceptives that are **brand-name prescription drugs** and devices unless:
 - A contraceptive that is a **generic prescription drug** or device equivalent, or alternative, is not available within the same **therapeutic drug class**.
 - A generic equivalent, or alternative, within the same **therapeutic drug class** is available, and:
 - You are granted a medical exception. Such exception requests shall be made by the **prescriber** to the Precertification Department of Our Pharmacy Management Department. Any waiver granted as a result of a medical exception shall be based upon an individual, case by case **medical necessity** determination and the waiver will not apply or extend to other covered persons; or
 - The **prescriber** specifies “Dispense As Written” (DAW).
3. Plan **copays** and **deductibles** apply to **brand-name prescription drugs** or devices that have a generic equivalent, or alternative, within the same **therapeutic drug class** when:
 - A medical exception is not granted; or
 - DAW is not specified.
4. A generic equivalent contains the identical amounts of the same active ingredients as the **brand name prescription drug** or device. A generic alternative is used for the same purpose, but can have different ingredients or different amounts of ingredients.

Oral Infertility Drugs

The following **prescription drugs** used for the purpose of treating infertility including, but not limited to:

- Progesterone.

Over-the-counter drugs (GR-96782 13-021 01 V/A)

Over-the-counter medications, as determined by the plan may be covered in an equivalent prescription dosage strength for the appropriate member responsibility. Coverage of the selected over-the-counter medications requires a **prescription**. You can access the list by logging onto www.Innovation-Health.com.

Precertification (GR-96782 13-010 10 V/A)

Precertification is required for certain outpatient **prescription drugs**. **Prescribers** must contact Us to request and obtain coverage for such **prescription drugs**. The list of drugs requiring **precertification** is subject to periodic review and change by Us. For the most up to date information, call the toll-free number on your member ID card or log on to your Navigator secure member website at www.Innovation-Health.com.

Benefits will be reduced or denied if We do not **precertify** your **prescription drug**. So ask your **prescriber** or pharmacist if your **prescription drug** needs to be **precertified**.

How to Obtain Precertification

If an outpatient **prescription drug** requires **precertification** and you use a **network pharmacy** the **prescriber** is required to obtain **precertification** for you.

When you use an **out-of-network pharmacy**, you can begin the **precertification** process by having the **prescriber** call Us at the number on your ID card. We will let your **prescriber** know if the **prescription drug** is **precertified** or not. If the prescription drug is denied **precertification**, We will notify you how the decision can be appealed.

Step-Therapy

Step-therapy is a type of **precertification**. With **step-therapy**, some **prescription drugs** will not be covered until you try one or more “prerequisite therapy” **prescription drugs**. Your **prescriber** can ask for a medical exception which is detailed below.

The plan will not cover the **step-therapy** drug if you do not try a prerequisite therapy **prescription drug** first or if your **prescriber** does not get a medical exception.

Step-therapy and prerequisite therapy **prescription drugs** are on Our **preferred drug list** available upon request or on your Navigator secure member website at www.innovation-health.com. The list of **step therapy** drugs are subject to change by Us.

Medical Exceptions

You or your **prescriber** may seek a medical exception to obtain coverage for drugs for which coverage is denied through **precertification** or **step therapy**. You or your **prescriber** must submit such exception requests to Us. Coverage granted as a result of a medical exception shall be based on an individual, case by case **medical necessity** determination and coverage will not apply or extend to other covered persons.

Pharmacy Benefit Limitations (GR-96782 13-015 007 V/A)

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.

The plan will not cover expenses for any **prescription drug** for which the actual charge to you is less than the required **copayment** or **deductible**, or for any **prescription drug** for which no charge is made to you.

You will be charged the **out-of-network prescription drug** cost sharing for **prescription drugs** recently approved by the U.S. Food and Drug Administration (FDA), but which have not yet been reviewed by Our Pharmacy and Therapeutics Committee.

We retain the right to review all requests for reimbursement and in its sole discretion make reimbursement determinations subject to the *Complaint and Appeals* section of this *Booklet-Certificate*.

The number of **copayments/deductibles** you are responsible for per vial of Depo-Provera, an injectable contraceptive, or similar type contraceptive dispensed for more than a 30 day supply, will be based on the 90 day supply level. Coverage is limited to a maximum of 5 vials per calendar year.

The plan will not pay charges for any **prescription drug** dispensed by a **mail order pharmacy** for the treatment of erectile dysfunction, impotence or sexual dysfunction or inadequacy.

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 from drug makers and other criteria developed by **Us** to set these quantity limits. The quantity limit may restrict either the amount dispensed per **prescription** order or refill.

Depending on the form and packing of the product, some **prescription drugs** are limited to a single commercially prepackaged item excluding insulin, diabetic supplies, test strips dispensed per **prescription** order or refill.

Depending on the form and packing of the product, some **prescription drugs** are limited to 100 units excluding insulin dispensed per **prescription** order or refill.

Any **prescription drug** that has duration of action extending beyond one (1) month shall require the number of **copayments** per prescribing unit that is equal to the anticipated duration of the medication. For example, a single injection of a drug that is effective for three (3) months would require three (3) **copayments**.

Specialty care prescription drugs may have limited access or distribution and are subject to supply limits.

Plan approved blood glucose meters, asthma holding chambers and peak flow meters are eligible health services, but are limited to one (1) **prescription** order per contract year.

Pharmacy Benefit Exclusions (GR-96782 28-020 10 V/A)

Not every health care service or supply is covered by the plan, even if prescribed, recommended, or approved by your **physician** or **dentist**. The plan covers only those services and supplies that are **medically necessary** and included in the *What the Plan Covers* section. Charges made for the following are not covered except to the extent listed under the *What the Plan Covers* section or by amendment attached to this *Booklet-Certificate*. In addition, some services are specifically limited or excluded. This section describes expenses that are not covered or subject to special limitations.

These **prescription drug** exclusions are in addition to the exclusions listed under your medical coverage.

The plan does not cover the following expenses:

Administration or injection of any drug.

Any charges in excess of the benefit, day, or supply limits stated in this *Booklet-Certificate*.

Allergy sera and extracts.

Any non-emergency charges incurred outside of the United States if you traveled to such location to obtain **prescription drugs**, or supplies, even if otherwise covered under this *Booklet-Certificate*. This also includes **prescription drugs** or supplies if:

- Such **prescription drugs** or supplies are unavailable or illegal in the United States; or
- The purchase of such **prescription drugs** or supplies outside the United States is considered illegal.

Any drugs or medications, services and supplies that are not **medically necessary**, as determined by Us, for the diagnosis, care or treatment of the **illness** or **injury** involved. This applies even if they are prescribed, recommended or approved by your **physician** or **dentist**.

Biological sera, blood, blood plasma, blood derivatives or substitutes or any other blood products. Coverage for blood and blood products is found under the medical expense benefit.

Contraceptive **prescription drugs**, devices, services and supplies (except as specifically described in the *Preventive Care Benefits* and *Additional Covered Expenses* section) including:

- Services associated with the prescribing, monitoring and/or administration of **prescription drug** contraceptives and devices.
- Female contraceptives that are **brand-name prescription drugs**; and
- FDA- approved female brand-name emergency contraceptives.

Contraception – Male condoms.

Cosmetic drugs, medications or preparations used for **cosmetic** purposes or to promote hair growth and removal, including but not limited to:

- health and beauty aids;
- chemical peels;
- dermabrasion;
- treatments;
- bleaching;
- creams;
- ointments or other treatments or supplies, to remove tattoos, scars or to alter the appearance or texture of the skin.

Devices and appliances that do not have the National Drug Code (NDC).

Dietary supplements including medical foods.

Drugs administered or entirely consumed at the time and place it is prescribed or dispensed.

Drugs for which the cost is recoverable under any federal, state, or government agency or any medication for which there is no charge made to the recipient.

Drugs which do not, by federal or state law, require a **prescription** order (i.e. over-the-counter (OTC) drugs), even if a **prescription** is written (except as specifically covered in the What the Pharmacy Plan Covers Section). .

Drugs provided by, or while the person is an inpatient in, any healthcare facility; or for any drugs provided on an outpatient basis in any such institution to the extent benefits are payable for it.

Drugs that include vitamins and minerals, both over-the-counter (OTC) and legend, except legend pre-natal vitamins for pregnant or nursing females, liquid or chewable legend pediatric vitamins for children under age 13, and potassium supplements to prevent/treat low potassium and legend vitamins that are medically necessary for the treatment of renal disease, hyperparathyroidism or other covered conditions with prior approval from us unless recommended by the United States Preventive Services Task Force (USPSTF).

Drugs used for methadone maintenance medications used for drug detoxification.

Drugs used for the purpose of weight gain or reduction, including but not limited to:

- stimulants;
- preparations;
- foods or diet supplements;
- dietary regimens and supplements;

- food or food supplements;
- appetite suppressants; and
- other medications.

Drugs used for the treatment of obesity.

Drugs used for the treatment of sexual dysfunction/enhancement.

All 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 precertification and clinical policies.

Drugs or medications that include the same active ingredient or a modified version of an active ingredient.

Drug or medication that is therapeutically equivalent or therapeutically alternative to a covered **prescription drug**.

Drug or medication that is therapeutically equivalent or therapeutically alternative to an over-the-counter (OTC) product.

Duplicative drug therapy (e.g. two antihistamine drugs).

Durable medical equipment, monitors and other equipment.

Experimental or investigational drugs or devices, except as described in the *What the Plan Covers* section.

This exclusion will not apply with respect to drugs that:

- Have been granted treatment investigational new drug (IND); or Group c/treatment IND status; or
- Are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; and
- We determine, based on available scientific evidence, are effective or show promise of being effective for the **illness**.

Food and nutritional items: Any food item, including:

- infant formulas;
- nutritional supplements;
- vitamins;
- medical foods and other nutritional items, even if it is the sole source of nutrition.

Genetics: Any treatment, device, drug, 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.

Immunization or immunological agents.

Implantable drugs and associated devices.

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 for diabetic needles and syringes;
- Injectable drugs if an alternative oral drug is available;
- For any refill of a designated self-injectable drug not dispensed by or obtained through the **specialty pharmacy network**.
- 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.

Insulin pumps or tubing or other ancillary equipment and supplies for insulin pumps.

Prescription drugs for which there is an over-the-counter (OTC) product which has the same active ingredient and strength even if a **prescription** is written.

Prescription drugs, medications, injectables or supplies given through a third party vendor contract with the policyholder.

Prescription drugs dispensed by a **mail order pharmacy** that include **prescription drugs** that cannot be shipped by mail due to state or federal laws or regulations, or when the plan considers shipment through the mail to be unsafe. Examples of these types of drugs include, but are not limited to, narcotics, amphetamines, DEA controlled substances and anticoagulants.

Prescription drugs that include an active metabolite, stereoisomer, prodrug (precursor) or altered formulation of another drug and is not clinically superior to that drug as determined by the plan.

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.

Prescription drugs that are **non-preferred drugs**, unless **non-preferred drugs** are specifically covered as described in your schedule of benefits. However, a **non-preferred drug** will be covered if in the judgment of the **prescriber** there is no equivalent **prescription drug** on the **preferred drug guide** or the product on the **preferred drug guide** is ineffective in treating your disease or condition or has caused or is likely to cause an adverse reaction or harm you.

Prescription drugs that are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, the use of or intended use of which would be illegal, unethical, imprudent, abusive, not **medically necessary**, or otherwise improper; and drugs obtained for use by anyone other than the member identified on the ID card.

Prescription orders filled prior to the effective date or after the termination date of coverage under this *Booklet-Certificate*.

Progesterone for the treatment of premenstrual syndrome (PMS) and compounded natural hormone therapy replacement.

Refills in excess of the amount specified by the **prescription** order. Before recognizing charges, We may require a new **prescription** or proof as to need, if a **prescription** or refill appears excessive under accepted medical practice standards.

Refills dispensed more than one year from the date the latest **prescription** order was written, or as otherwise allowed by applicable law of the jurisdiction in which the drug is dispensed.

Replacement of lost or stolen **prescriptions**.

Drugs, services and supplies given in connection with treatment of an **occupational injury** or **occupational illness**.

Tobacco use: 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. This includes medications, nicotine patches and gum.

Strength and performance: Drugs or preparations, devices and supplies to enhance strength, physical condition, endurance or physical performance, including performance enhancing steroids.

Sex change: Any treatment, drug or supply related to changing sex or sexual characteristics, including hormones and hormone therapy.

Supplies, devices or equipment of any type, except as specifically provided in the *What the Plan Covers* section.

Test agents except diabetic test agents.

When Coverage Ends (GR-96782 30-005 07)

Coverage under your plan can end for a variety of reasons. In this section, you will find details on how and why coverage ends, and how you may still be able to continue coverage.

When Coverage Ends for Employees

Your coverage under the plan will end if:

- The plan is discontinued;
- You voluntarily stop your coverage;
- The group policy ends;
- You are no longer eligible for coverage;
- You do not make any required contributions;
- You become covered under another plan offered by your employer;
- Your employment stops for any reason, including a job elimination or being placed on severance. This will be either the date you stop active work, or the day before the first premium due date that occurs after you stop active work. However, if premium payments are made on your behalf, We may deem your employment to continue, for purposes of remaining eligible for coverage under this Plan, as described below:
 - If you are not actively at work due to **illness or injury**, your coverage may continue, until stopped by your employer, but not beyond 3 months from the start of your absence.
 - If you are not actively at work due to temporary lay-off or leave of absence, your coverage will stop on your last full day you are actively at work before the start of the lay-off or leave of absence.

It is your employer's responsibility to let Us know when your employment ends. The limits above may be extended only if We and your employer agree, in writing, to extend them.

Your Proof of Prior Medical Coverage (GR-96782 30-010 01)

Under the Health Insurance Portability and Accountability Act of 1996, your employer is required to give you a certificate of **creditable coverage** when your employment ends. This certificate proves that you were covered under this plan when you were employed. Ask your employer about the certificate of **creditable coverage**.

When Coverage Ends for Dependents (GR-96782 30-015 07)

Coverage for your dependents will end if:

- You are no longer eligible for dependents' coverage;
- You do not make your contribution toward the cost of dependents' coverage;
- Your own coverage ends for any of the reasons listed under *When Coverage Ends for Employees* section;

- Your dependent is no longer eligible for coverage. In this case, coverage ends at the end of the calendar month when your dependent does not meet the plan's definition of a dependent; or
- Your dependent becomes eligible for comparable benefits under this or any other group plan offered by your employer.

In addition to the rules above, a "domestic partner" will no longer be considered to be a defined dependent on the earlier to occur of:

- The date this plan no longer allows coverage for domestic partners.
- The date of termination of the domestic partnership.

Important Note:

Coverage for dependents may continue for a period after your death. Coverage for handicapped dependents may continue after they reach any limiting age. See the *Continuation of Coverage* section for more information.

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Continuing Health Expense Coverage (GR96782 31-015 08)

Continuing Coverage for Dependents After Your Death

Continuing Coverage for Dependent Students on Medical Leave of Absence (GR96782 31-015 08)

If your dependent child who is eligible for coverage and enrolled in this plan by reason of his or her status as a full-time student at a postsecondary educational institution ceases to be eligible due to:

- a **medically necessary** leave of absence from school; or
- a change in his or her status as a full-time student,

resulting from a serious **illness** or **injury**, such child's coverage under this plan may continue.

Coverage under this continuation provision will end when the first of the following occurs:

- The end of the 12 month period following the first day of your dependent child's leave of absence from school, or a change in his or her status as a full-time student;
- Your dependent child's coverage would otherwise end under the terms of this plan;
- Dependent coverage is discontinued under this plan; or
- You fail to make any required contribution toward the cost of this coverage.

To be eligible for this continuation, the dependent child must have been enrolled in this plan and attending school on a full-time basis immediately before the first day of the leave of absence.

To continue your dependent child's coverage under this provision you should notify your employer as soon as possible after your child's leave of absence begins or the change in his or her status as a full-time student. We may require a written certification from the treating **physician** which states that the child is suffering from a serious **illness** or **injury** and that the resulting leave of absence (or change in full-time student status) is **medically necessary**.

Important Note

If at the end of this 12 month continuation period, your dependent child's leave of absence from school (or change in full-time student status) continues, such child may qualify for a further continuation of coverage under the *Handicapped Dependent Children* provision of this plan. Please see the section, *Handicapped Dependent Children*, for more information.

Handicapped Dependent Children (GR96782 31-015 08)

Health Expense Coverage for your fully handicapped dependent child may be continued past the maximum age for a dependent child. However, such coverage may not be continued if the child has been issued an individual medical conversion policy.

Your child is fully handicapped if:

- he or she is not able to earn his or her own living because of intellectual disability or a physical handicap which started prior to the date he or she reaches the maximum age for dependent children under your plan; and
- he or she depends chiefly on you for support and maintenance.

Proof that your child is fully handicapped must be submitted to Us no later than 31 days after the date your child reaches the maximum age under your plan.

Coverage will cease on the first to occur of:

- Cessation of the handicap;
- Failure to give proof that the handicap continues;
- Failure to have any required exam; or
- Termination of dependent coverage as to your child for any reason other than reaching the maximum age under your plan.

We will have the right to require proof of the continuation of the handicap. We also have the right to examine your child as often as needed while the handicap continues at our own expense. An exam will not be required more often than once each year after 2 years from the date your child reached the maximum age under your plan.

Important Note

Your dependent may be eligible to convert to an Individual Medical Insurance Policy. Please see the section, *Converting to an Individual Health Insurance Policy* for more information.

Extension of Benefits (GR96782 31-020 01)

Extended Health Coverage

Medical Benefits (other than Basic medical benefits): Coverage will be available while you are totally disabled, but only for the condition that caused the disability, for up to 12 months.

Prescription Drug Benefits: Coverage will be available while you are totally disabled for up to 12 months.

When Extended Health Coverage Ends

Extension of benefits will end on the first to occur of the date:

- You are no longer totally disabled, or become covered under any other group plan with like benefits.
- Your dependent is no longer totally disabled, or he or she becomes covered under any other group plan with like benefits.

(This does not apply if coverage ceased because the benefit section ceased for your eligible class.)

Important Note

If the Extension of Benefits provision outlined in this section applies to you or your covered dependents, see the *Converting to an Individual Health Insurance Policy* section for important information.

COBRA Continuation of Coverage (GR-96782 31-025 02 V.A)

If your employer is subject to COBRA requirements, the health plan continuation is governed by the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requirements. With COBRA you and your dependents can continue health coverage, subject to certain conditions and your payment of premiums. Continuation rights are available following a “qualifying event” that would cause you or family members to otherwise lose coverage. Qualifying events are listed in this section.

Continuing Coverage through COBRA

When you or your covered dependents become eligible, your employer will provide you with detailed information on continuing your health coverage through COBRA.

You or your dependents will need to:

- Complete and submit an application for continued health coverage, which is an election notice of your intent to continue coverage.
- Submit your application within 60 days of the qualifying event, or within 60 days of your employer’s notice of this COBRA continuation right, if later.
- Agree to pay the required premiums.

Who Qualifies for COBRA

You have 60 days from the qualifying event to elect COBRA. If you do not submit an application within 60 days, you will forfeit your COBRA continuation rights.

Below you will find the qualifying events and a summary of the maximum coverage periods according to COBRA requirements.

Qualifying Event Causing Loss of Health Coverage	Covered Persons Eligible to Elect Continuation	Maximum Continuation Periods
Your active employment ends for reasons other than gross misconduct	You and your dependents	18 months
Your working hours are reduced	You and your dependents	18 months
You divorce or legally separate and are no longer responsible for dependent coverage	Your dependents	36 months
You become entitled to benefits under Medicare	Your dependents	36 months
Your covered dependent children no longer qualify as dependents under the plan	Your dependent children	36 months
You die	Your dependents	36 months
You are a retiree eligible for health coverage and your former employer files for bankruptcy	You and your dependents	18 months

Disability May Increase Maximum COBRA Continuation to 29 Months

If You or Your Covered Dependents Are Disabled

If you or your covered dependent qualify for disability status under Title II or XVI of the Social Security Act during the 18 month continuation period, you or your covered dependent:

- Have the right to extend coverage beyond the initial 18 month maximum continuation period.
- Qualify for an additional 11 month period, subject to the overall COBRA conditions.
- Must notify your employer within 60 days of the disability determination status and before the 18 month continuation period ends.
- Must notify the employer within 30 days after the date of any final determination that you or a covered dependent are no longer disabled.
- Are responsible to pay the premiums after the 18th month, through the 29th month.

If There Are Multiple Qualifying Events

A covered dependent could qualify for an extension of the 18 or 29 month continuation period by meeting the requirements of another qualifying event, such as divorce or death. The total continuation period, however, can never exceed 36 months.

Determining Your Premium Payments For COBRA Continuation Coverage

Your premiums are regulated by law, based on the following:

- For the 18 or 36 month periods, premiums may never exceed 102 percent of the plan costs.
- During the 18 through 29 month period, premiums for coverage during an extended disability period may never exceed 150 percent of the plan costs.

When You Acquire a Dependent During a COBRA Continuation Period

If through birth, adoption or marriage, you acquire a new dependent during the continuation period, your dependent can be added to the health plan for the remainder of the continuation period if:

- He or she meets the definition of an eligible dependent,
- Your employer is notified about your dependent within 31 days of eligibility, and
- Additional premiums for continuation are paid on a timely basis.

Important Note

For more information about dependent eligibility, see the *Eligibility, Enrollment and Effective Date* section.

When Your COBRA Continuation Coverage Ends

Your COBRA coverage will end when the first of the following events occurs:

- You or your covered dependents reach the maximum COBRA continuation period – the end of the 18, 29 or 36 months. (Coverage for a newly acquired dependent who has been added for the balance of a continuation period would end at the same time your continuation period ends, if he or she is not disabled nor eligible for an extended maximum).
- You or your covered dependents do not pay required premiums.
- You or your covered dependents become covered under another group plan that does not restrict coverage for preexisting conditions. If your new plan limits preexisting condition coverage, the continuation coverage under this plan may remain in effect until the preexisting clause ceases to apply or the maximum continuation period is reached under this plan.
- The date your employer no longer offers a group health plan.
- The date you or a covered dependent becomes enrolled in benefits under Medicare. This does not apply if it is contrary to the Medicare Secondary Payer Rules or other federal law.
- You or your dependent dies.

Conversion from a Group to an Individual Plan

You may be eligible to apply for an individual health plan without providing proof of good health:

- At the termination of employment.
- When loss of coverage under the group plan occurs.
- When loss of dependent status occurs.
- At the end of the maximum health coverage continuation period.

The individual policy will not provide the same coverage as the former group plan offered by your employer. Certain benefits may not be available. You will be required to pay the associated premium costs for the coverage. For additional information concerning this conversion option, please refer to the *Converting to an Individual Health Insurance Plan* section of your *Booklet-Certificate*, contact your employer or call the toll-free number on your member ID card.

Converting to an Individual Medical Insurance Policy (GR-96782 31-040 02 V/A)

Eligibility

You and your covered dependents may apply for an individual Medical insurance policy if you lose coverage under the group medical plan because:

- You terminate your employment;
- You are no longer in an eligible class;
- Your dependent no longer qualifies as an eligible dependent;
- Any continuation coverage required under federal or state law has ended; or
- You retire and there is no medical coverage available.

You can only use the conversion option once. If your group plan allows retirees to continue medical coverage, and you wish to continue your plan, then the conversion privilege will not be available to you again.

The individual conversion policy may cover:

- You only; or
- You and all dependents who are covered under the group plan at the time your coverage ended; or
- Your covered dependents, if you should die before you retire.

Features of the Conversion Policy

The individual policy and its terms will be the type:

- Required by law or regulation for group conversion purposes in your or your dependent's states of residence; and
- Offered by Us when you or your dependents apply under your employer's conversion plan.

However, coverage will not be the same as your group plan coverage. Generally, the coverage level may be less.

The individual policy may also:

- Reduce its benefits by any like benefits payable under your group plan after coverage ends (for example: if benefits are paid after coverage ends because of a disability extension of benefits);
- Not guarantee renewal under selected conditions described in the policy.

Limitations

You or your dependents do not have a right to convert if:

- Medical coverage under the group contract has been discontinued.
- You or your dependents are eligible for Medicare. Covered dependents not eligible for Medicare may apply for

individual coverage even if you are eligible for Medicare.

- Coverage under the plan has been in effect for less than three months.
- You or your covered dependents become eligible for any other medical coverage under this plan.
- You apply for individual coverage in a jurisdiction where We cannot issue or deliver an individual conversion policy.
- You or your covered dependents are eligible for, or have benefits available under, another plan that, in addition to the converted policy, would either match benefits or result in over insurance. Examples include:
 - Any other **hospital** or surgical expense insurance policy;
 - Any **hospital** service or medical expense indemnity corporation subscriber contract;
 - Any other group contract; or
 - Any statute, welfare plan or program.

Electing an Individual Conversion Policy

You or your covered dependents must apply for an individual policy within 31 days after issuance of the written notice required by your employer, but in no event beyond the 60-day period following the date of the termination of your coverage. You do not need to provide proof of good health if you apply within this period.

To apply for an individual medical insurance policy:

- Get a copy of the “Notice of Conversion Privilege and Request” form from your employer.
- Complete and send the form to Us at the specified address.

Your Premiums and Payments

Your first premium payment will be due at the time you submit the conversion application to Us.

The amount of the premium will be Our normal rate for the policy that is approved for issuance in your or your dependent’s state of residence.

When an Individual Policy Becomes Effective

The individual policy will begin on the day after coverage ends under your group plan. Your policy will be issued once We receive and process your completed application and premium payment.

Coordination of Benefits

(GR-96782 33-005 01 V.A)

Benefits Subject To This Provision

Definitions

Order of Benefit Determination

Effect on Benefits of This Plan

Benefits Subject To This Provision

This Coordination of Benefits (COB) provision applies to this plan when you or your covered dependent has health coverage under more than one plan. “Plan” and “This Plan” are defined herein. The Order of Benefit Determination Rules below determines which plan will pay as the primary plan. The primary plan pays first without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100% of the total allowable expense.

Definitions

When used in this provision, the following words and phrases have the meaning explained herein.

Allowable Expense means a health care service or expense, including, **coinsurance** and **copayments**, without reduction of any applicable **deductible**, that is covered at least in part by any of the **Plans** covering the person. When a **Plan** provides benefits in the form of services (for example an HMO), the reasonable cash value of each service will be considered an **allowable expense** and a benefit paid. An expense or service that is not covered by any of the **Plans** is not an **allowable expense**. Any expense that a health care provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an **allowable expense**. The following are examples of expenses and services that are not **allowable expenses**:

1. If a covered person is confined in a private **hospital** room, the difference between the cost of a semi-private room in the **hospital** and the private room is not an **allowable expense**. This does not apply if one of the **Plans** provides coverage for a private room.
2. If a person is covered by 2 or more **Plans** that compute their benefit payments on the basis of reasonable or **recognized charges**, any amount in excess of the highest of the reasonable or **recognized charges** for a specific benefit is not an **allowable expense**.
3. If a person is covered by 2 or more **Plans** that provide benefits or services on the basis of negotiated charges, an amount in excess of the highest of the negotiated charges is not an **allowable expense**.
4. The amount a benefit is reduced or not reimbursed by the **primary plan** because a covered person does not comply with the **Plan** provisions is not an **allowable expense**. Examples of these provisions are second surgical opinions, **precertification** of admissions, and preferred provider arrangements.
5. If all **Plans** covering a person are high deductible **Plans** and the person intends to contribute to a health savings account established in accordance with section 223 of the Internal Revenue Code of 1986, the primary high deductible **Plan's deductible** is not an **allowable expense**, except as to any health expense that may not be subject to the **deductible** as described in section 223(c)(2)(C) of the Internal Revenue Code of 1986.

If a person is covered by one **Plan** that computes its benefit payments on the basis of reasonable or **recognized charges** and another **Plan** that provides its benefits or services on the basis of **negotiated charges**, the **primary plan's** payment arrangements shall be the **allowable expense** for all the **Plans**. However, if the **secondary plan** has a negotiated fee or payment amount different from the **primary plan** and if the provider contract permits, that negotiated fee will be the **allowable expense** used by the **secondary plan** to determine benefits.

When a **plan** provides benefits in the form of services, the reasonable cash value of each service rendered shall be deemed an **allowable expense** and a benefit paid.

Closed Panel Plan(s). A plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the **plan**, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial Parent. A parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Plan. Any **Plan** providing benefits or services by reason of health care or treatment, which benefits or services are provided by one of the following:

- Group or blanket health insurance policies issued by insurers, including health care service contractors;
- Other prepaid coverage under service plan contracts, or under group or individual practice;
- Uninsured arrangements of group or group-type coverage;
- Labor-management trustee plans, labor organization plans, employer organization plans, or employee benefit organization plans;
- **Medicare** or other governmental benefits;
- Other group-type contracts. Group type contracts are those which are not available to the general public and can be obtained and maintained only because membership in or connection with a particular organization or group.

If the **Plan** includes medical, **prescription drug**, vision and hearing coverage, those coverages will be considered separate **plans**. For example, Medical coverage will be coordinated with other Medical **plans**, and vision coverage will be coordinated with other vision **plans**.

This Plan is any part of the policy that provides benefits for health care expenses.

Primary Plan/Secondary Plan. The order of benefit determination rules state whether **This Plan** is a **Primary Plan** or **Secondary Plan** as to another **Plan** covering the person.

When **This Plan** is a **Primary Plan**, its benefits are determined before those of the other **Plan** and without considering the other **Plan's** benefits.

When **This Plan** is a **Secondary Plan**, its benefits are determined after those of the other **Plan** and may be reduced because of the other **Plan's** benefits.

When there are more than two **Plans** covering the person, **This Plan** may be a **Primary Plan** as to one or more other **Plans**, and may be a **Secondary Plan** as to a different **Plan** or **Plans**.

Order of Benefit Determination (GR-96782 33-010 01)

When two or more plans pay benefits, the rules for determining the order of payment are as follows:

- The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.
- A plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan **hospital** and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.
- A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.

The first of the following rules that describes which plan pays its benefits before another plan is the rule to use:

1. Non-Dependent or Dependent. The plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the plan that covers the person as a dependent is secondary. However, if the person is a **Medicare** beneficiary and, as a result of federal law, **Medicare** is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.
2. Child Covered Under More than One Plan. The order of benefits when a child is covered by more than one plan is:
 - A. The primary plan is the plan of the parent whose birthday is earlier in the year if:
 - i. The parents are married or living together whether or not married;
 - ii. A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage or if the decree states that both parents are responsible for health coverage. If both parents have the same birthday, the plan that covered either of the parents longer is primary.
 - B. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health coverage for the dependent child's health care expenses, but that parent's spouse does, the plan of the parent's spouse is the primary plan.
 - C. If the parents are separated or divorced or are not living together whether or not they have ever been married and there is no court decree allocating responsibility for health coverage, the order of benefits is:
 - The plan of the custodial parent;
 - The plan of the spouse of the **custodial parent**;
 - The plan of the **noncustodial parent**; and then
 - The plan of the spouse of the **noncustodial parent**.

For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits should be determined as outlined above as if the individuals were the parents.

3. Active Employee or Retired or Laid off Employee. The plan that covers a person as an employee who is neither laid off nor retired or as a dependent of an active employee, is the primary plan. The plan covering that same person as a retired or laid off employee or as a dependent of a retired or laid off employee is the secondary plan. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.
4. Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.
5. Longer or Shorter Length of Coverage. The plan that covered the person as an employee, member, or subscriber longer is primary.
6. If the preceding rules do not determine the primary plan, the allowable expenses shall be shared equally between the plans meeting the definition of plan under this provision. In addition, This Plan will not pay more than it would have paid had it been primary.

Effect on Benefits of This Plan (GR-96782 33-015 03 V/A)

When this plan is secondary, it may reduce its benefits so that total benefits paid or provided by all plans during a claim determination period are not more than 100% of total **allowable expenses**. The difference between the benefit payments that this plan would have paid had it been the **primary plan**, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the covered person and used by this plan to pay any **allowable expenses**, not otherwise paid during the claim determination period.

In addition, a **secondary plan** will credit to its plan **deductible** any amounts that would have been credited in the absence of other coverage.

Under the COB provision of **This Plan**, the amount normally reimbursed for covered benefits or expenses under **This Plan** is reduced to take into account payments made by other plans. The general rule is that the benefits otherwise payable under **This Plan** for all covered benefits or expenses will be reduced by all other plan benefits payable for those expenses. When the COB rules of **This Plan** and another plan both agree that **This Plan** determines its benefits before such other plan, the benefits of the other plan will be ignored in applying the general rule above to the claim involved. Such reduced amount will be charged against any applicable benefit limit of this coverage.

If a covered person is enrolled in two or more **closed panel plans** COB generally does not occur with respect to the use of panel providers. However, COB may occur if a person receives emergency services that would have been covered by both plans.

Right To Receive And Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits under this **Plan** and other **plans**. We have the right to release or obtain any information and make or recover any payments it considers necessary in order to administer this provision.

Facility of Payment

Any payment made under another **Plan** may include an amount, which should have been paid under **This Plan**. If so, We may pay that amount to the organization, which made that payment. That amount will then be treated as though it were a benefit paid under **This Plan**. We will not have to pay that amount again. The term “payment made” means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by Us is more than it should have paid under this COB provision, it may recover the overpayment from the person or entity that was overpaid and the refund should be from the payment made to the member or provider or entity that received the payment in error. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

Effect of Medicare

(GR-96782 33-020 01)

Order of Benefit Determination

How Coordination with Medicare Works

How Coordination with Medicare Works

This section explains how the benefits under **This Plan** interact with benefits available under **Medicare**.

Medicare, when used in this *Booklet-Certificate*, means the health insurance provided by Title XVIII of the Social Security Act, as amended. It includes Health Maintenance Organization (HMO) or similar coverage that is an authorized alternative to Parts A and B of **Medicare**

You are eligible for **Medicare** if you are:

- Covered under it by reason of age, disability, or
- End Stage Renal Disease; or
- Not covered under it because you:
 1. Refused it;
 2. Dropped it; or
 3. Failed to make a proper request for it.

If you are eligible for **Medicare**, the plan coordinates the benefits it pays with the benefits that **Medicare** pays. Sometimes, the **plan** is the primary payor, which means that the **plan** pays benefits before **Medicare** pays benefits. Under other circumstances, the **plan** is the secondary payor, and pays benefits after **Medicare**.

Order of Benefit Determination

The plan is the primary payor when your coverage for the **plan's** benefits is based on current employment with your employer. The **plan** will act as the primary payor for the **Medicare** beneficiary who is eligible for **Medicare**:

- Solely due to age if the **plan** is subject to the Social Security Act requirements for **Medicare** with respect to working aged (i.e., generally a plan of an employer with 20 or more employees);
- Due to diagnosis of end stage renal disease, but only during the first 30 months of such eligibility for **Medicare** benefits. This provision does not apply if, at the start of eligibility, you were already eligible for **Medicare** benefits, and the **plan's** benefits were payable on a secondary basis;
- Solely due to any disability other than end stage renal disease; but only if the **plan** meets the definition of a large group health plan as outlined in the Internal Revenue Code (i.e., generally a plan of an employer with 100 or more employees).

The plan is the secondary payor in all other circumstances.

How Coordination With Medicare Works

When the Plan is Primary

The **plan** pays benefits first when it is the primary payor. You may then submit your claim to **Medicare** for consideration.

When Medicare is Primary

Your health care expense must be considered for payment by **Medicare** first. You may then submit the expense to Us for consideration.

We will calculate the benefits the **plan** would pay in the absence of **Medicare**:

The amount will be reduced so that when combined with the amount paid by **Medicare**, the total benefits paid or provided by all plans for the claim do not exceed 100 percent of the total **allowable expense**.

This review is done on a claim-by-claim basis.

Charges used to satisfy your Part B deductible under **Medicare** will be applied under the **plan** in the order received by Us. We will apply the largest charge first when two or more charges are received at the same time.

We will apply any rule for coordinating health care benefits after determining the benefits payable.

Right to Receive and Release Required Information *(GR-96782 33-025 01)*

Certain facts about health care coverage and services are required to apply Coordination of Benefits (COB) rules to determine benefits under **This Plan** and other **plans**. We have the right to obtain or release any information, and make or recover any payments We consider necessary, in order to administer this provision.

General Provisions (GR-96782 32-005 05 V/A)

Type of Coverage

Coverage under the plan is **non-occupational**. Only **non-occupational** accidental **injuries** and **non-occupational illnesses** are covered. The plan covers charges made for services and supplies only while the person is covered under the plan.

Physical Examinations

We will have the right and opportunity to have a **physician** of Our choice examine any person who is requesting certification or benefits for new and ongoing claims. Multiple exams, evaluations and functional capacity exams may be required during your disability for an ongoing claim. This will be done at all reasonable times while a certification or a claim for benefits is pending or under review. This will be done at no cost to you.

Legal Action

No legal action can be brought to recover payment under any benefit within 60 days after written proof of loss has been given. No legal action can be brought to recover payment under any benefit after 3 years from the deadline for filing claims.

We will not try to reduce or deny a benefit payment on the grounds that a condition existed before your coverage went into effect, if the loss occurs more than 2 years from the date coverage commenced. This will not apply to conditions excluded from coverage on the date of the loss.

Confidentiality

Information contained in your medical records and information received from any provider incident to the provider-patient relationship shall be kept confidential in accordance with applicable law. Information may be used or disclosed by Us when necessary for your care or treatment, the operation of the plan and administration of this *Booklet-Certificate*, or other activities, as permitted by applicable law. You can obtain a copy of Our *Notice of Information Practices* by calling the Member Services number on the back of your ID card.

Additional Provisions

The following additional provisions apply to your coverage.

- This *Booklet-Certificate* applies to coverage only, and does not restrict your ability to receive health care services that are not, or might not be, covered.
- You cannot receive multiple coverage under this Plan because you are connected with more than one employer.
- You cannot be covered as both an active employee and a retired employee.
- In the event of a misstatement of any fact affecting your coverage under the plan, the true facts will be used to determine the coverage in force.
- This document describes the main features of the plan. Additional provisions are described elsewhere in the *Group Policy*. If you have any questions about the terms of this plan or about the proper payment of benefits, contact your employer or Us.
- Your employer hopes to continue the plan indefinitely but, as with all group plans, this plan may be changed or discontinued with respect to your coverage.

Assignments

An assignment is the transfer of your rights under the group policy to a person you name.

Coverage may be assigned only with Our written consent. To the extent allowed by law, We will not accept an assignment to an **out-of-network provider**, including but not limited to, an assignment of:

- The benefits due under this group insurance policy;
- The right to receive payments due under this group insurance policy; or
- Any claim you make for damages resulting from a breach or alleged breach, of the terms of this group insurance policy.

Misstatements

If any fact as to the Policyholder or you is found to have been misstated, a fair change in premiums may be made. If the misstatement affects the existence or amount of coverage, the true facts will be used in determining whether coverage is or remains in force and its amount.

All statements made by the Policyholder or you shall be deemed representations and not warranties. No written statement made by you shall be used by Us in a contest unless a copy of the statement is or has been furnished to you or your beneficiary, or the person making the claim.

Our failure to implement or insist upon compliance with any provision of this policy at any given time or times, shall not constitute a waiver of Our right to implement or insist upon compliance with that provision at any other time or times. This includes, but is not limited to, the payment of premiums. This applies whether or not the circumstances are the same.

Incontestability

Except as to a fraudulent misstatement, or issues concerning Premiums due:

- No statement made by the Policyholder or you or your dependent shall be the basis for voiding coverage or denying coverage or be used in defense of a claim unless it is in writing after it has been in force for 2 years from its effective date.
- No statement made by the Policyholder shall be the basis for voiding this Policy after it has been in force for 2 years from its effective date.
- No statement made by you or your dependent shall be used in defense of a claim for loss incurred or starting after coverage as to which claim is made has been in effect for 2 years. Such statements must be in writing and signed by you or your dependent.

Rescission of Coverage

We may rescind your coverage if you, or the person seeking coverage on your behalf:

- Performs an act, practice or omission that constitutes fraud; or
- Makes an intentional misrepresentation of material fact.

You will be given 30 days advance written notice of any rescission of coverage. You may be entitled to a refund of any paid premiums from the effective date of coverage if coverage is voided or rescinded.

As to medical and prescription drug coverage only, you have the right to an internal **Appeal** with Us and/or the right to a third party review conducted by an independent **External Review** Organization if your coverage under this *Booklet-Certificate* is rescinded retroactive to its Effective Date.

Recovery of Overpayments (GR-96782 32-015 01 V/A)

Health Coverage

If a benefit payment is made by Us, to or on your behalf, which exceeds the benefit amount that you are entitled to receive, We have the right to require the return of the overpayment from you or the entity that was overpaid and the refund should be from the payment made to you or the provider or entity that received the payment in error.

Such right does not affect any other right of recovery We may have with respect to such overpayment.

Reporting of Claims (GR-96782 32-020 04-V/A)

For All Benefit Plans

You are required to submit a claim to Us in writing. Claim forms may be obtained from the Policyholder or from Us. We will supply you with a claim form within fifteen (15) days of your request.

Your claim must give proof of the nature and extent of the charge incurred for the covered service or supply. You must furnish true and correct information as We may reasonably request. At any time, We may require copies of documents to support your claim, including data about employment.

As show below, additional rules apply to the reporting of claims depending upon the coverage provided under your plan.

Health Insurance Claims

A claim must be submitted to Us within 90 days after the date the charge was incurred for the covered service or supply. All claims must give proof of the nature and extend of the charges incurred for the covered service or supply. We and your Policyholder have claim forms.

If, through no fault of your own, you are not able to meet the deadline for filing claim, your claim will still be accepted if you file as soon as possible. Unless you are legally incapacitated, late claims for health benefits will not be covered if they are filed more than 2 years after the deadline.

Fraud

Any person who, with intent to defraud or knowing that he is facilitating a fraud against Us, provides Us with false information or files a claim for benefits that contains any material false information or conceals for the purpose of misleading, information concerning any material fact, may have violated state law.

Payment of Benefits (GR-96782 32-025 07 V/A)

Benefits will be paid as soon as the necessary proof to support the claim is received but not more than 60 days. Written proof must be provided for all benefits.

All covered health expense benefits are payable to you. However, We have the right to pay any health benefits to the service provider. This will be done unless you have told Us otherwise by the time you file the claim. We will notify you in writing, at the time We receive a claim, when an assignment of benefits to a health care provider or facility will not be accepted.

We may pay up to \$2,000 of any other benefit to any of your relatives whom it believes fairly entitled to it. This can be done if the benefit is payable to you and you are a minor or not able to give a valid release. It can also be done if a benefit is payable to your estate.

When a **physician** provides care for you or a covered dependent, or care is provided by a **network provider** on referral by your **physician (network services or supplies)**, the **network provider** will take care of filing claims. However, when you seek care on your own (**out-of-network services and supplies**), you are responsible for filing your own claims.

Records of Expenses (GR-96782 32-030 03)

Keep complete records of the expenses of each person. They will be required when a claim is made.

Very important are:

- Names of **physicians, dentists** and others who furnish services.
- Dates expenses are incurred.
- Copies of all bills and receipts.

Contacting Us

If you have questions, comments or concerns about your benefits or coverage, or if you are required to submit information to Us, you may contact Our Home Office at:

Innovation Health Insurance Company
3190 Fairview Park Drive
5th Floor Suite 570
Falls Church, VA 22042

You may also use Our toll free Member Services phone number on your ID card or visit Our web site at www.innovation-health.com.

Effect of Benefits Under Other Plans (GR-96782 32-035 01)

Effect of An Health Maintenance Organization Plan (HMO Plan) On Coverage

If you are in an eligible class and have chosen coverage under an HMO Plan offered by your employer, you will be excluded from medical expense coverage (except Vision Care), if any, on the date of your coverage under such HMO Plan.

If you are in an eligible class and are covered under an HMO Plan, you can choose to change to coverage for yourself and your covered dependents under this plan. If you:

- Live in an HMO Plan enrollment area and choose to change coverage during an open enrollment period, coverage will take effect on the group policy anniversary date after the open enrollment period. There will be no rules for waiting periods or preexisting conditions.
- Live in an HMO Plan enrollment area and choose to change coverage when there is not an open enrollment period, coverage will take effect only if and when We give Our written consent.
- Move from an HMO Plan enrollment area or if the HMO discontinues and you choose to change coverage within 31 days of the move or the discontinuance, coverage will take effect on the date you elect such coverage. There will be no restrictions for waiting periods or preexisting conditions. If you choose to change coverage after 31 days, coverage will take effect only if and when We give Our written consent.

Any extensions of benefits under this plan for disability or pregnancy will not always apply on and after the date of a change to an HMO Plan providing medical coverage. They will apply only if the person is not covered at once under the HMO Plan because he or she is in a **hospital** not affiliated with the HMO. If you give evidence that the HMO Plan provides an extension of benefits for disability or pregnancy, coverage under this plan will be extended. The extension will be for the same length of time and for the same conditions as the HMO Plan provides. It will not be longer than the first to occur of:

- The end of a 90 day period; and
- The date the person is not confined.

No benefits will be paid for any charges for services rendered or supplies furnished under an HMO Plan.

Effect of Prior Coverage - Transferred Business (GR-96782 32-040 04)

If your coverage under any part of this plan replaces any prior coverage for you, the rules below apply to that part.

"Prior coverage" is any plan of group coverage that has been replaced by coverage under part or all of this plan. The plan must have been sponsored by your employer (e.g., transferred business). The replacement can be complete or in part for the eligible class to which you belong. Any such plan is prior coverage if provided by another group contract or any benefit section of this plan.

Coverage under any other section of this plan will be in exchange for all privileges and benefits provided under any like prior coverage. Any benefits provided under such prior coverage may reduce benefits payable under this plan.

Incentives (GR-96782 32-045 05 V/A)

In order to encourage you to access certain medical services when deemed appropriate by you in consultation with your **physician** or other service providers, We may, from time to time, offer to waive or reduce your **copayment**, **coinsurance**, and/or a **deductible** otherwise required under the plan or offer coupons or other financial incentives. We have the right to determine the amount and duration of any waiver, reduction, coupon, or financial incentive and to limit the covered persons to whom these arrangements are available.

Appeals Procedure (GR-96782 32-050 01 V/A)

Definitions

Adverse Benefit Determination (Decision): A denial; reduction; termination of; or failure to; provide or make payment (in whole or in part) for a service, supply or benefit.

Such **adverse benefit determination** may be based on:

- Your eligibility for coverage.
- Coverage determinations, including plan limitations or exclusions.
- The results of any Utilization Review activities.
- A decision that the service or supply is **experimental or investigational**.
- A decision that the service or supply is not **medically necessary**.

As to medical and **prescription drug** claims only, an **adverse benefit determination** also means the termination of your coverage back to the original effective date (rescission) as it applies under any rescission of coverage provision of the *Booklet-Certificate*.

Adverse Determination. A determination made by Us that based on the information provided, a request for a benefit upon application of any utilization review technique does not meet Our requirements for **medical necessity**,

appropriateness, health care setting, level of care, or effectiveness or is determined to be **experimental or investigational** and the requested benefit is therefore denied, reduced or terminated or payment is not provided or made, in whole or in part for the benefit.

Appeal: A written request to Us to reconsider an **adverse benefit determination**.

Complaint: Any written expression of dissatisfaction about quality of care or the operation of the Plan.

Concurrent Care Claim Extension: A request to extend a course of treatment that was previously approved.

Concurrent Care Claim Reduction or Termination: A decision to reduce or terminate a course of treatment that was previously approved.

External Review: A review of an **adverse determination** or a **final adverse determination** by an Independent Review Organization (IRO) assigned by the Virginia State Corporation Commission (the “Commission”) and made up of **physicians** or other appropriate health care **providers**. The IRO must have expertise in the problem or question involved.

Final Adverse Benefit Determination: An **adverse benefit determination** that has been upheld by Us at the exhaustion of the appeals process.

Pre-service Claim: Any claim for medical care or treatment that requires approval before the medical care or treatment is received.

Post-Service Claim: Any claim that is not a “Pre-Service Claim.”

Urgent Care Claim: Any claim for medical care or treatment in which a delay in treatment could:

- Seriously jeopardize your life or health;
- Jeopardize your ability to regain maximum function;
- Cause you to suffer severe pain that cannot be adequately managed without the requested medical care or treatment; or
- In the case of a pregnant woman, cause serious jeopardy to the health of the fetus.

Special Note:

Only **adverse determinations** and **final adverse determinations** are eligible for **external review**.

Full and Fair Review of Claim Determinations and Appeals

As to medical and **prescription drug** claims and **appeals** only, We will provide you with any new or additional evidence considered and rationale, relied upon, or generated by us in connection with the claim at issue. This will be provided to you in advance of the date on which the notice of the **final adverse benefit determination** is required to be provided so that you may respond prior to that date.

Prior to issuing a **final adverse benefit determination** based on a new or additional rationale, you must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which notice of **final adverse benefit determination** is required.

Claim Determinations

Notice of a claim benefit decision will be provided to you in accordance with the guidelines and timelines provided below. As to medical and **prescription drug** claims only, if We make an **adverse benefit determination**, written notice will be provided to you, or in the case of a concurrent care claim, to your **provider**.

Timeframe for Notification of a Claim Determination

We will respond to a request for services that require utilization review within 2 business days once We have all the information necessary to complete the review.

We will respond to any request for a prescription drug to alleviate the pain caused by cancer within 24 hours.

Complaints

If you are dissatisfied with the service you receive from the Plan or want to complain about a **provider** you must write Member Services. The complaint must include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. We will review the information and provide you with a written response within 30 calendar days of the receipt of the **complaint**, unless more information is needed and it cannot be obtained within this period. The notice of the decision will tell you what you need to do to seek an additional review.

Appeals of Adverse Benefit Determinations

You may submit an **appeal** if We give notice of an **adverse benefit determination**. This Plan provides for one level or two levels of **appeal**. As to medical and **prescription drug** claims only, a **final adverse determination** notice may also provide an option to request an **External Review**.

You have 180 calendar days from the date of receipt of the notice of an **adverse benefit determination** to request your **appeal**. Your **appeal** must be submitted in writing and must include:

- Your name.
- The Policyholder's name.
- A copy of Our notice of an **adverse benefit determination**.
- Your reasons for making the **appeal**.
- Any other information you would like to have considered.

Send your written **appeal** to Member Services at the address shown on your ID Card, or call in your **appeal** to Member Services using the telephone number shown on your ID Card.

You may also choose to have another person (an authorized representative) make the **appeal** on your behalf. You must provide written consent to Us.

As to medical and **prescription drug** claims only, you may be allowed to provide evidence or testimony during the **appeal** process in accordance with the guidelines established by the Federal Department of Health and Human Services.

If you have any questions regarding your **appeal** or the health care services that have been provided, which have not been satisfactorily addressed by Us, you may contact the Office of the Managed Care Ombudsman or the Virginia Department of Health's Complaint Unit for assistance at the following addresses, telephone numbers, e-mail addresses or internet sites:

Office of the Managed Care Ombudsman
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
Toll Free: 1-877-310-6560
Richmond Metropolitan Area: 804-371-9032
E-mail: ombudsman@scc.virginia.gov
Internet site: www.scc.virginia.gov

Complaint Unit
Office of Licensure and Certification
Virginia Department of Health
9960 Mayland Drive
Suite 401
Henrico, VA 23233-1463
Toll Free: 1-800-955-1819
Richmond Metropolitan Area: 804-367-2106
Fax: 1-804-527-4503
E-mail: OLC-Complaints@vdh.virginia.gov

Level One Appeal

A review of a Level One **Appeal** of an **adverse benefit determination** shall be provided by Our personnel. They shall not have been involved in making the **adverse benefit determination**.

Urgent Care Claims (May Include Concurrent Care Claim Reduction or Termination)

We shall issue a decision within 24 hours for **appeals** that relate to a prescription to alleviate cancer pain and for all other **appeals** within 36 hours of receipt of the request for an **appeal**.

A **Concurrent Care Claim Extension** will be treated like an **urgent care claim**.

Pre-Service Claims (May Include Concurrent Care Claim Reduction or Termination)

We shall issue a decision within 15 calendar days of receipt of the request for an **appeal**.

Post-Service Claims

We shall issue a decision within 30 calendar days of receipt of the request for an **appeal**.

Level Two Appeal

If We uphold an **adverse benefit determination** at the first level of **appeal**, and the reason for the decision was based on **medical necessity** or **experimental or investigational** reasons, you or your authorized representative have the right to file a Level Two **Appeal**. The **appeal** must be submitted within 60 calendar days following the receipt of a decision of a Level One **Appeal**.

Review of a Level Two **Appeal** of an **adverse benefit determination** of an **urgent care claim**, a **Pre-Service Claim**, or a **Post-Service Claim** shall be provided by Our personnel. They shall not have been involved in making the **adverse benefit determination** or **Level One Appeal decision**.

Urgent Care Claims (May Include Concurrent Care Claim Reduction or Termination)

We shall issue a decision within 24 hours for **appeals** that relate to a prescription to alleviate cancer pain and for all other **appeals** within 36 hours of receipt of the request for a Level Two **Appeal**.

A **Concurrent Care Claim Extension** will be treated like an **urgent care claim**.

Pre-Service Claims (May Include Concurrent Care Claim Reduction or Termination)

We shall issue a decision within 15 calendar days of receipt of the request for a Level Two **Appeal**.

Post-Service Claims

We shall issue a decision within 30 calendar days of receipt of the request for a Level Two **Appeal**.

Exhaustion of Process

You are encouraged to exhaust the applicable processes of the Appeal Procedure before you request an investigation of or file a complaint with the Virginia Bureau of Insurance.

You must receive a **final adverse determination** from Us before filing a request for an **External Review** with the Virginia Bureau of Insurance, except as outlined below and as described in the **External Review** section.

The foregoing procedures and processes are mandatory and must be exhausted before establishing any:

- litigation;
- arbitration; or
- administrative proceeding;

regarding an alleged breach of the policy terms by Us or any matter within the scope of the Appeals Procedure.

As to medical and **prescription drug** claims only, under certain circumstances you may seek simultaneous review through the internal Appeals Procedure and **External Review** processes—these include **Urgent Care Claims** and situations where you are receiving an ongoing course of treatment. Exhaustion of the applicable process of the Appeal Procedure is not required under these circumstances.

Important Note:

As to medical and **prescription drug** claims only if We do not adhere to all claim determination and **appeal** requirements of the Federal Department of Health and Human Services, you are considered to have exhausted the **appeal** requirements and may proceed with **External Review** or any of the actions mentioned above. There are limits, though, on what sends a claim or **appeal** straight to an **External Review**. Your claim or internal **appeal** will not go straight to **External Review** if:

- a rule violation was minor and isn't likely to influence a decision or harm you;
- it was for a good cause or was beyond Our control; and
- it was part of an ongoing, good faith exchange between you and Us.

You or your authorized representative, or a **provider** acting on your behalf may request a written explanation of the violation from Us. We must provide such explanation of the violation within ten (10) days, including a specific description of its basis, if any, for asserting that the violation should not cause the internal **complaint** and **appeals** process to be deemed exhausted.

If an external reviewer or a court rejects your request, your authorized representative's request, or your **provider's** request for immediate review on the basis that We met the standards for the exception set forth in this section, you, your authorized representative, or your **provider** has the right to resubmit and pursue the internal **appeal** of the claim. An **appeal** should be made within a reasonable time after the external reviewer or court rejects the claim for immediate review, not to exceed five (5) days. We must provide notice of the opportunity to resubmit and pursue the internal **appeal**. The time period for submitting the **appeal** begins when you, your authorized representative or your **provider** receives notice.

External Review

You or your authorized representative may request an **External Review** if:

As to medical and **prescription drug** claims only, you received an **adverse determination** or **final adverse determination** because We determined that:

- The claim involved medical judgment;
- The care was not **medically necessary** or appropriate; or
- A service, supply or treatment was **experimental or investigational** in nature.

You or your authorized representative may also request an **External Review** before exhausting **Our** internal process if:

- you have a medical condition where the time frame for completion of the faster internal **appeal** of an **adverse determination** would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function;
- the **adverse determination** involved a denial of coverage based on a determination that the recommended or requested health care service or treatment was **experimental or investigational** and your treating physician certified in writing that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated;
- you or their authorized representative filed a request for a faster internal **appeal** of an **adverse determination** with Us, in which case the IRO assigned to conduct the **external review** will determine whether you should be required to complete the internal **appeal** before conducting the **external review**; or
- you or you authorized representative has filed a standard **appeal** of an **adverse determination** with Us and We have not issued a written decision within 30 days of the **appeal** requesting the review and you or your authorized representative have not agreed to a delay.

The notice of **adverse determination** or **final adverse determination** that you receive from **Us** will describe the process to follow if you wish to pursue an **External Review**, and will include copies of the *Request for External Review Forms*.

You must submit the *Request for External Review Forms* to the Commission within 120 calendar days of the date you received the **adverse determination** or **final adverse determination** notice. You also must include a copy of the notice and all other pertinent information that supports your request.

The Commission will contact the IRO that will conduct the review of your claim. The IRO will select one or more independent clinical reviewers with appropriate expertise to perform the review. In making a decision, the external reviewer may consider any appropriate credible information that you send along with the *Request for External Review Forms*, and will follow Our contractual documents and the terms of coverage under your health benefit plan. You will be notified of the decision of the IRO usually within 45 calendar days of the IRO's receipt of your request forms and all the necessary information.

A faster review is possible if your **physician** certifies (by telephone or on separate *Request for External Review Forms*) that a delay in receiving the service would:

- Seriously jeopardize your life or health; or
- Jeopardize your ability to regain maximum function; or
- If the **adverse determination** relates to **experimental or investigational** treatment, if the **physician** certifies that the recommended or requested health care service, supply or treatment would be significantly less effective if not promptly initiated.

You may also receive a faster review if the **final adverse determination** relates to an admission; availability of care; continued **stay**; or health service for which you received **emergency care**, but have not been discharged from a facility.

Faster reviews are decided within 72 hours after We receive the request.

We will abide by the decision of the IRO, except where We can show conflict of interest, bias or fraud.

You are responsible for the cost of compiling and sending the information that you wish to be reviewed by the IRO to Us. We are responsible for the cost of sending this information to the IRO and for the cost of the external review except for vision and hearing claims.

For more information about the **appeals** procedure or **External Review** processes, call the **Member Services** telephone number shown on your ID card.

Glossary

(GR-96782 34-005 08)

In this section, you will find definitions for the words and phrases that appear in **bold type** throughout the text of this *Booklet-Certificate*.

A

Ambulance

A vehicle that is staffed with medical personnel and equipped to transport an ill or injured person.

Average Wholesale Price (AWP)

The current **average wholesale price** of a **prescription drug** listed in the Facts and Comparisons weekly price updates (or any other similar publication designated by Us) on the day that a **pharmacy** claim is submitted for adjudication.

B (GR-96782 34-010 01 V/A)

Behavioral Health Provider/Practitioner

A licensed organization or professional providing diagnostic, therapeutic or psychological services for behavioral health conditions.

Biologically-Based Mental Illness

Any mental or nervous condition caused by a biological disorder of the brain that results in a clinically significant syndrome that substantially limits the person's functioning; specifically, the following diagnoses are defined as biologically-based mental illnesses as they apply to adults and children:

- Attention deficit hyperactivity disorder.
- Autism.
- Bipolar disorder.
- Drug and alcohol addiction.
- Major depressive disorder.
- Obsessive-compulsive disorder.
- Panic disorder.
- Schizo-affective disorder.
- Schizophrenia.

Treatment is generally provided by; or under the direction of; a **behavioral health provider** such as a psychiatrist; a psychologist; or a psychiatric social worker.

Birthing Center

A freestanding facility that meets all of the following requirements:

- Meets licensing standards.
- Is set up, equipped and run to provide prenatal care, delivery and immediate postpartum care.
- Charges for its services.
- Is directed by at least one **physician** who is a **specialist** in obstetrics and gynecology.
- Has a **physician** or certified nurse midwife present at all births and during the immediate postpartum period.
- Extends staff privileges to **physicians** who practice obstetrics and gynecology in an area **hospital**.
- Has at least 2 beds or 2 birthing rooms for use by patients while in labor and during delivery.

- Provides, during labor, delivery and the immediate postpartum period, full-time **skilled nursing services** directed by an **R.N.** or certified nurse midwife.
- Provides, or arranges with a facility in the area for, diagnostic X-ray and lab services for the mother and child.
- Has the capacity to administer a local anesthetic and to perform minor surgery. This includes episiotomy and repair of perineal tear.
- Is equipped and has trained staff to handle **emergency medical conditions** and provide immediate support measures to sustain life if:
 - Complications arise during labor; or
 - A child is born with an abnormality which impairs function or threatens life.
- Accepts only patients with low-risk pregnancies.
- Has a written agreement with a **hospital** in the area for emergency transfer of a patient or a child. Written procedures for such a transfer must be displayed and the staff must be aware of them.
- Provides an ongoing quality assurance program. This includes reviews by **physicians** who do not own or direct the facility.
- Keeps a medical record on each patient and child.

Body Mass Index

This is a practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

Brand-Name Prescription Drug

A **prescription drug** with a proprietary name assigned to it by the manufacturer or distributor and so indicated by Medi-Span or any other similar publication designated by Us or an affiliate.

C (GR-96782 34-015 07 V/A)

Coinsurance

Coinsurance is both the percentage of **covered expenses** that the plan pays, and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as “plan **coinsurance**” and varies by the type of expense. Please refer to the *Schedule of Benefits* for specific information on **coinsurance** amounts.

Copay or Copayment

The specific dollar amount or percentage required to be paid by you or on your behalf. The plan includes various **copayments**, and these **copayment** amounts or percentages are specified in the *Schedule of Benefits*.

Cosmetic

Services or supplies that alter, improve or enhance appearance.

Covered Expenses

Medical, dental, vision or hearing services and supplies shown as covered under this Booklet.

Creditable Coverage

A person’s prior medical coverage as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Such coverage includes:

- Health coverage issued on a group or individual basis;
- Medicare;
- Medicaid;
- Health care for members of the uniformed services;
- A program of the Indian Health Service;

- A state health benefits risk pool;
- The Federal Employees' Health Benefit Plan (FEHBP);
- A public health plan (any plan established by a State, the government of the United States, or any subdivision of a State or of the government of the United States, or a foreign country);
- Any health benefit plan under Section 5(e) of the Peace Corps Act; and
- The State Children's Health Insurance Program (S-CHIP).

Custodial Care

Services and supplies that are primarily intended to help you meet personal needs. **Custodial care** can be prescribed by a **physician** or given by trained medical personnel. It may involve artificial methods such as feeding tubes, ventilators or catheters. Examples of **custodial care** include:

- Routine patient care such as changing dressings, periodic turning and positioning in bed, administering 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 stable indwelling 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, including **room and board** for rest cures, adult day care and convalescent care;
- Help with the daily living activities, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods;
- Any services that a person without medical or paramedical training could be trained to perform; and
- Any service that can be performed by a person without any medical or paramedical training.

D (GR-96782 34-020 03)

Day Care Treatment

A **partial confinement treatment** program to provide treatment for you during the day. The **hospital, psychiatric hospital** or **residential treatment facility** does not make a room charge for **day care treatment**. Such treatment must be available for at least 4 hours, but not more than 12 hours in any 24-hour period.

Deductible

The part of your **covered expenses** you pay before the plan starts to pay benefits. Additional information regarding **deductibles** and **deductible** amounts can be found in the *Schedule of Benefits*.

Dentist

A legally qualified **dentist**, or a **physician** licensed to do the dental work he or she performs.

Detoxification

The process by which an alcohol-intoxicated or drug-intoxicated; or an alcohol-dependent or drug-dependent person is medically managed through the period of time necessary to eliminate, by metabolic or other means, the:

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

as determined by a **physician**. The process must keep the physiological risk to the patient at a minimum, and take place in a facility that meets any applicable licensing standards established by the jurisdiction in which it is located.

Directory

A listing of all **network providers** serving the class of employees to which you belong. The policyholder will give you a copy of this **directory**. **Network provider** information is also available through Our online provider **directory**, DocFind®.

Durable Medical and Surgical Equipment (DME)

Equipment, and the accessories needed to operate it, that is:

- Made to withstand prolonged use;
- Made for and mainly used in the treatment of an **illness** or **injury**;
- Suited for use in the home;
- Not normally of use to people who do not have an **illness** or **injury**;
- Not for use in altering air quality or temperature; and
- Not for exercise or training.

Durable medical and surgical equipment does not include equipment such as whirlpools, portable whirlpool pumps, sauna baths, massage devices, over bed tables, elevators, communication aids, vision aids and telephone alert systems.

E (GR-96782 34-025 09 V/A)

Emergency Care

This means the treatment given in a **hospital's** emergency room to evaluate and treat an **emergency medical condition**.

Emergency Medical Condition

A recent and severe medical condition, including (but not limited to) severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, **illness**, or **injury** is of such a nature that failure to get immediate medical care could result in:

- Placing your physical or mental health in serious jeopardy; or
- Serious impairment to bodily function; or
- Serious dysfunction of a body part or organ; or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Experimental or Investigational

A drug, a device, a procedure, or treatment will be determined to be **experimental or investigational** if:

- There are insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the **illness** or **injury** involved; or
- Approval required by the U. S. Food and Drug Administration (FDA) has not been granted for marketing; or
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is **experimental or investigational**, or for research purposes; or
- It is a type of drug, device or treatment that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial, using the definition of “phases” indicated in regulations and other official actions and publications of the FDA and Department of Health and Human Services; or
- The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is **experimental or investigational**, or for research purposes.

G *(GR-96782 34-035 01)*

Generic Prescription Drug

A **prescription drug**, whether identified by its chemical, proprietary, or non-proprietary name, that is accepted by the U.S. Food and Drug Administration as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient and so indicated by Medispan or any other publication designated by Us or an affiliate.

H *(GR-96782 34-040 02)*

Homebound

This means that you are confined to your place of residence:

- Due to an **illness** or **injury** which makes leaving the home medically contraindicated; or
- Because the act of transport would be a serious risk to your life or health.

Situations where you would not be considered **homebound** include (but are not limited to) the following:

- You do not often travel from home because of feebleness or insecurity brought on by advanced age (or otherwise); or
- You are wheelchair bound but could safely be transported via wheelchair accessible transportation.

Home Health Care Agency

An agency that meets all of the following requirements.

- Mainly provides skilled nursing and other therapeutic services.
- Is associated with a professional group (of at least one **physician** and one **R.N.**) which makes policy.
- Has full-time supervision by a **physician** or an **R.N.**
- Keeps complete medical records on each person.
- Has an administrator.
- Meets licensing standards.

Home Health Care Plan

This is a plan that provides for continued care and treatment of an **illness** or **injury**. The care and treatment must be:

- Prescribed in writing by the attending **physician**; and
- An alternative to a **hospital** or **skilled nursing facility stay**.

Hospice Care

This is care given to a **terminally ill** person by or under arrangements with a **hospice care agency**. The care must be part of a **hospice care program**.

Hospice Care Agency

An agency or organization that meets all of the following requirements:

- Has **hospice care** available 24 hours a day.
- Meets any licensing or certification standards established by the jurisdiction where it is located.
- Provides:
 - **Skilled nursing services**;
 - Medical social services; and
 - Psychological and dietary counseling.

- Provides, or arranges for, other services which include:
 - **Physician** services;
 - Physical and occupational therapy;
 - Part-time home health aide services which mainly consist of caring for **terminally ill** people; and
 - Inpatient care in a facility when needed for pain control and acute and chronic symptom management.
- Has at least the following personnel:
 - One **physician**;
 - One **R.N.**; and
 - One licensed or certified social worker employed by the agency.
- Establishes policies about how **hospice care** is provided.
- Assesses the patient's medical and social needs.
- Develops a **hospice care program** to meet those needs.
- Provides an ongoing quality assurance program. This includes reviews by **physicians**, other than those who own or direct the agency.
- Permits all area medical personnel to utilize its services for their patients.
- Keeps a medical record on each patient.
- Uses volunteers trained in providing services for non-medical needs.
- Has a full-time administrator.

Hospice Care Program

This is a written plan of **hospice care**, which:

- Is established by and reviewed from time to time by a **physician** attending the person, and appropriate personnel of a **hospice care agency**;
- Is designed to provide palliative and supportive care to **terminally ill** persons, and supportive care to their families; and
- Includes an assessment of the person's medical and social needs; and a description of the care to be given to meet those needs.

Hospice Facility

A facility, or distinct part of one, that meets all of the following requirements:

- Mainly provides inpatient **hospice care** to **terminally ill** persons.
- Charges patients for its services.
- Meets any licensing or certification standards established by the jurisdiction where it is located.
- Keeps a medical record on each patient.
- Provides an ongoing quality assurance program including reviews by **physicians** other than those who own or direct the facility.
- Is run by a staff of **physicians**. At least one staff **physician** must be on call at all times.
- Provides 24-hour-a-day nursing services under the direction of an **R.N.**
- Has a full-time administrator.

Hospital

An institution that:

- Is primarily engaged in providing, on its premises, inpatient medical, surgical and diagnostic services;
- Is supervised by a staff of **physicians**;
- Provides twenty-four (24) hour-a-day **R.N.** service,
- Charges patients for its services;
- Is operating in accordance with the laws of the jurisdiction in which it is located; and

- Does not meet all of the requirements above, but does meet the requirements of the jurisdiction in which it operates for licensing as a **hospital** and is accredited as a **hospital** by the Joint Commission on the Accreditation of Healthcare Organizations.

In no event does **hospital** include a convalescent nursing home or any institution or part of one which is used principally as a convalescent facility, rest facility, nursing facility, facility for the aged, extended care facility, intermediate care facility, **skilled nursing facility**, hospice, rehabilitative **hospital** or facility primarily for rehabilitative or custodial services.

Hospitalization

A continuous confinement as an inpatient in a **hospital** for which a **room and board** charge is made.

I (GR-96782 34-045 02 V/A)

Illness

A pathological condition of the body that presents a group of clinical signs and symptoms and laboratory findings peculiar to the findings set the condition apart as an abnormal entity differing from other normal or pathological body states.

Infertile or Infertility

The condition of a presumably healthy covered person who is unable to conceive or produce conception after:

- For a woman who is under 35 years of age: 1 year or more of timed, unprotected coitus, or 12 cycles of artificial insemination; or
- For a woman who is 35 years of age or older: 6 months or more of timed, unprotected coitus, or 6 cycles of artificial insemination.

Injury

An accidental bodily **injury** that is the sole and direct result of:

- An unexpected or reasonably unforeseen occurrence or event; or
- The reasonable unforeseeable consequences of a voluntary act by the person.
- An act or event must be definite as to time and place.

Institute of Excellence (IOE)

A **hospital** or other facility that has contracted with Us to furnish services or supplies to an **IOE** patient in connection with specific transplants, procedures at a **negotiated charge**. A facility is an **IOE** facility only for those types of transplants, procedures for which it has signed a contract.

J (GR-96782 34-050 01)

Jaw Joint Disorder

This is:

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

L (GR-96782 34-055 01)

Late Enrollee

This is an employee in an Eligible Class who asked for enrollment under this Plan after the Initial Enrollment Period. Also, this is an eligible dependent for whom the employee did not choose coverage for the Initial Enrollment Period, but for whom coverage is asked for at a later time.

An eligible employee or dependent may not be considered a **Late Enrollee** at certain times. See the Special Enrollment Periods section of the (Booklet-Certificate).

L.P.N.

A licensed practical or vocational nurse.

M (GR-96782 34-065 07 V/A)

Mail Order Pharmacy

An establishment where **prescription drugs** are legally given out by mail or other carrier.

Maintenance Care

Care made up of services and supplies that:

- Are given mainly to maintain, rather than to improve, a level of physical, or mental function; and
- Give a surrounding free from exposures that can worsen the person's physical or mental condition.

Maximum Out-of-Pocket Limit

Your plan has a **maximum out-of-pocket limit**. Your **deductibles**, **coinsurance**, **copayments** and other eligible out-of-pocket expense apply to the **maximum out-of-pocket limit**. Once you meet the maximum amount the plan will pay 100% of **covered expenses** that apply toward the limit for the rest of the **Calendar Year**. The **maximum out-of-pocket limit** applies to both network and out-of-network out-of-pocket expenses.

The following expenses do not apply toward your **maximum out-of-pocket limits**:

- Charges over the **recognized charge**,
- **Non-covered expenses**,
- Expenses for non-emergency use of the emergency room,
- Expenses incurred for non-urgent use of an urgent care provider, and
- Expenses that are not paid or precert benefit reductions made because a **precertification** is needed for the services or supply was not obtained from Us.

Medically Necessary, Medical Necessity

Health care or dental services, and supplies or **prescription drugs** that a **physician**, other health care provider or **dental provider**, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an **illness** or **injury** or its symptoms, and that provision of the service, supply or **prescription drug** is:

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

For these purposes “generally accepted standards of medical or dental practice” means standards that are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental

community, or otherwise consistent with **physician** or dental specialty society recommendations and the views of **physicians** or **dentists** practicing in relevant clinical areas and any other relevant factors.

N (GR-96782 34-070 08 V.A)

Negotiated Charge

As to health expense coverage, other than Prescription Drug Expense Coverage:

The **negotiated charge** is the maximum charge a **network provider** has agreed to make as to any service or supply for the purpose of the benefits under this plan.

As to Prescription Drug Expense Coverage:

The **negotiated charge** is the amount We have established for each **prescription drug** obtained from a **network pharmacy** under this plan. This **negotiated charge** may reflect amounts We have 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.

The **negotiated charge** does not include or reflect any amount We, an affiliate, or a third party vendor, may receive under a rebate arrangement between Us, an affiliate or a third party vendor and a drug manufacturer for any **prescription drug**, including **prescription drugs** on the **preferred drug guide**.

Based on its overall drug purchasing, We may receive rebates from the manufacturers of **prescription drugs** and may receive or pay additional amounts from or to third parties under price guarantees. These amounts will not change the **negotiated charge** under this plan.

Network Advanced Reproductive Technology (ART) Specialist

A specialist **physician** who has entered into a contractual agreement with Us for the provision of covered **Advanced Reproductive Technology (ART)** services.

Network Provider

A health care provider or a **pharmacy** who has contracted to furnish services or supplies for this plan; but only if the provider is, with Our consent, included in the **directory** as a **network provider** for:

- The service or supply involved; and
- The class of employees to which you belong.

Network Service(s) or Supply(ies)

Health care service or supply that is:

- Furnished by a **network provider**

Night Care Treatment

A **partial confinement treatment** program provided when you need to be confined during the night. A room charge is made by the **hospital, psychiatric hospital or residential treatment facility**. Such treatment must be available at least:

- 8 hours in a row a night; and
- 5 nights a week.

Non-Occupational Illness

A **non-occupational illness** is an **illness** that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an **illness** that does.

An **illness** will be deemed to be non-occupational regardless of cause if proof is furnished that the person:

- Is covered under any type of workers' compensation law; and
- Is not covered for that **illness** under such law.

Non-Occupational Injury

A **non-occupational injury** is an accidental bodily **injury** that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an **injury** which does.

Non-Preferred Drug (Non-Formulary)

A **prescription drug** that is not listed in the **preferred drug guide**. This includes **prescription drugs** on the **preferred drug guide exclusions list** that are approved by medical exception.

Non-Specialist

A **physician** who is not a **specialist**.

Non-Urgent Admission

An inpatient admission that is not an **emergency admission** or an **urgent admission**.

O

(GR-96782 34-075 07 VA)

Occupational Injury or Occupational Illness

An **injury** or **illness** that:

- Arises out of (or in the course of) any activity in connection with employment or self-employment whether or not on a full time basis; or
- Results in any way from an **injury** or **illness** that does.

Occurrence

This means a period of disease or **injury**. An **occurrence** ends when 60 consecutive days have passed during which the covered person:

- Receives no medical treatment; services; or supplies; for a disease or **injury**; and
- Neither takes any medication, nor has any medication prescribed, for a disease or **injury**.

Orthodontic Treatment

This is any:

- Medical service or supply; or
- Dental service or supply;

furnished to prevent or to diagnose or to correct a misalignment:

- Of the teeth; or
- Of the bite; or
- Of the jaws or jaw joint relationship;

whether or not for the purpose of relieving pain.

The following are not considered **orthodontic treatment**:

- The installation of a space maintainer; or
- A surgical procedure to correct malocclusion.

Out-of-Network Service(s) and Supply(ies)

Health care service or supply that is furnished by an **out-of network provider**.

Out-of-Network Provider

A health care provider or a **pharmacy** who has not contracted with Us, an affiliate, or a third party vendor, to furnish services or supplies for this plan.

P (GR-96782 34-080 09 V/A)

Pharmacy

An establishment where **prescription drugs** are legally dispensed. **Pharmacy** includes a retail **pharmacy**, **mail order pharmacy** and **specialty pharmacy network pharmacy**.

Physician

A duly licensed member of a medical profession who:

- Has an M.D. or D.O. degree;
- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where the individual practices;
- Provides medical services which are within the scope of his or her license or certificate;
- Specializes in psychiatry, if your **illness** or **injury** is caused, to any extent, by alcohol abuse, drug abuse, or a biologically-based or non-biologically-based **mental illness**; and
- Is not you or related to you.

This also includes a health professional who:

- Under applicable insurance law, are considered a "physician" for purposes of this coverage and;
- Are properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices;
- Provide medical services which are within the scope of his or her license or certificate;
- Have the medical training and clinical expertise suitable to treat your condition;
- Specialize in behavioral health, if your **illness** or **injury** is caused, to any extent, by alcohol abuse, drug abuse, or a biologically-based or non-biologically-based **mental illness**; and
- Are not you or related to you.

Precertification or Precertify

A process where We are contacted before certain services are provided, such as **hospitalization** or outpatient surgery, or **prescription drugs** are prescribed to determine whether the services being recommended or the drugs prescribed are considered **covered expenses** under the plan. It is not a guarantee that benefits will be payable.

Preferred Network Pharmacy

A **network retail pharmacy** that has contracted with **Us**, an affiliate, or a third party vendor, to provide outpatient **prescription drugs** that we have identified as a **preferred network pharmacy**.

Prescriber

Any **physician** or **dentist**, acting within the scope of his or her license, who has the legal authority to write an order for a **prescription drug**.

Prescription

An order for the dispensing of a **prescription drug** by a **prescriber**. If it is an oral order, it must be promptly put in writing by the pharmacy.

Prescription Drug

A drug, biological, or compounded **prescription** which, by State and Federal Law, may be dispensed only by **prescription** and which is required to be labeled "Caution: Federal Law prohibits dispensing without prescription." This includes:

- An injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include injectable insulin.

Psychiatric Hospital

This is an institution that meets all of the following requirements.

- Mainly provides a program for the diagnosis, evaluation, and treatment of alcohol abuse, drug abuse or a **biologically-based** or non-biologically-based **mental illness**.
- Is not mainly a school or a custodial, recreational or training institution.
- Provides infirmatory-level medical services. Also, it provides, or arranges with a **hospital** in the area for, any other medical service that may be required.
- Is supervised full-time by a **psychiatrist** who is responsible for patient care and is there regularly.
- Is staffed by **psychiatrists** involved in care and treatment.
- Has a **psychiatrist** present during the whole treatment day.
- Provides, at all times, **psychiatric** social work and nursing services.
- Provides, at all times, **skilled nursing services** by licensed nurses who are supervised by a full-time **R.N.**
- Prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs. The plan must be supervised by a **psychiatrist**.
- Makes charges.
- Meets licensing standards.

Psychiatrist

This is a **physician** who:

- Specializes in psychiatry; or
- Has the training or experience to do the required evaluation and treatment of alcohol abuse, drug abuse or a **biologically-based** or non-biologically-based **mental illness**.

Recognized Charge (GR-96782 34-090 13 V/A)

The amount of an **out-of-network provider's** charge that is eligible for coverage. You are responsible for all amounts above the **recognized charge**. The **recognized charge** may be less than the provider's full charge.

Your plan's **recognized charge** applies to all out-of-network **covered expenses** except out of network **emergency services**. In all cases, the **recognized charge** is determined based on the Geographic Area where you receive the service or supply.

A service or supply provided by a **provider** is treated as **covered expenses** under the **other health care** coverage category when:

- You get services or supplies from an **out-of-network provider**. This includes when you get care from **out-of-network providers** during your **stay** in a **network hospital**.
- You could not reasonably get the services and supplies needed from a **network provider**.

The **other health care** coverage does not apply to services or supplies you receive in an **out-of-network** emergency room.

When the **other health care** coverage applies, you will pay the **other health care** cost share.

Except as otherwise specified below, the **recognized charge** for each service or supply is the lesser of what the **provider** bills and:

- For professional services and for other services or supplies not mentioned below:
 - 180% of the Medicare allowable rate
- For services of **hospitals** and other facilities:
 - 225% of the Medicare allowable rate
- For **prescription drugs**:
 - 110% of the Average wholesale price (AWP)

For **emergency services**, the **recognized charge** is the **negotiated charge** for providers with whom we have a direct contract but are not **network providers**.

We have the right to apply **Aetna** reimbursement policies. Those policies may further reduce the **recognized charge**. These policies take into account factors such as:

- The duration and complexity of a service
- When multiple procedures are billed at the same time, whether additional overhead is required
- Whether an assistant surgeon is necessary for the service
- If follow up care is included
- Whether other characteristics modify or make a particular service unique
- When a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided and
- The educational level, licensure or length of training of the **provider**

Aetna reimbursement policies are based on our review of:

- The Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate
- Generally accepted standards of medical and dental practice and
- The views of **physicians** and dentists practicing in the relevant clinical areas

We use commercial software to administer some of these policies. Some policies are different for professional services than for facility services.

Special terms used

Average wholesale price (AWP), Geographic area, and Medicare allowable rates are defined as follows:

Average wholesale price (AWP)

Is the current average wholesale price of a **prescription drug** listed in the Medi-span weekly price updates (or any other similar publication chosen by **Aetna**).

Geographic area

The Geographic area made up of the first three digits of the U.S. Postal Service zip codes. If we determine we need more data for a particular service or supply, we may base rates on a wider Geographic area such as an entire state.

Medicare allowable rates

Except as specified below, these are the rates CMS establishes for services and supplies provided to Medicare enrollees. We update our systems with these revised rates within 180 days of receiving them from CMS. If Medicare does not have a rate, we will determine the rate as follows:

- Use the same method CMS uses to set Medicare rates.
- Look at what other providers charge.
- Look at how much work it takes to perform a service.
- Look at other things as needed to decide what rate is reasonable for a particular service or supply.

Additional information:

Get the most value out of your benefits. Use the “Estimate the Cost of Care” tool on Aetna Navigator® to help decide whether to get care in network or out-of-network. **Aetna’s** secure member website at www.aetna.com may contain additional information which may help you determine the cost of a service or supply. Log on to Aetna Navigator® to access the “Estimate the Cost of Care” feature. Within this feature, view our “Cost of Care” and “Member Payment Estimator” tools.

Rehabilitation Facility

A facility, or a distinct part of a facility which provides **rehabilitative services**, meets any licensing or certification standards established by the jurisdiction where it is located, and makes charges for its services.

Residential Treatment Facility (Alcoholism and Drug Abuse)

This is an institution that meets all of the following requirements:

- On-site licensed **Behavioral Health Provider** 24 hours per day/7 days a week.
- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).
- Is admitted by a **Physician**.
- Has access to necessary medical services 24 hours per day/7 days a week.
- If you require **detoxification** services, must have the availability of on-site medical treatment 24 hours per day/7 days a week, which must be actively supervised by an attending **Physician**.
- Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs.
- Offers group therapy sessions with at least an **R.N.** or Masters-Level Health Professional.
- Has the ability to involve family/support systems in therapy (required for children and adolescents; encouraged for adults).
- Provides access to at least weekly sessions with a **Psychiatrist** or psychologist for individual psychotherapy.
- Has peer oriented activities.
- Services are managed by a licensed **Behavioral Health Provider** who, while not needing to be individually contracted, needs to (1) meet Our credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director).

- Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission.
- Provides a level of skilled intervention consistent with patient risk.
- Meets any and all applicable licensing standards established by the jurisdiction in which it is located.
- Is not a Wilderness Treatment Program or any such related or similar program, school and/or education service.
- Ability to assess and recognize withdrawal complications that threaten life or bodily functions and to obtain needed services either on site or externally.
- 24-hours per day/7 days a week supervision by a **physician** with evidence of close and frequent observation.
- On-site, licensed **Behavioral Health Provider**, medical or **substance abuse** professionals 24 hours per day/7 days a week.

Residential Treatment Facility (Mental Disorders)

This is an institution that meets all of the following requirements:

- On-site licensed **Behavioral Health Provider** 24 hours per day/7 days a week.
- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).
- Is admitted by a **Physician**.
- Has access to necessary medical services 24 hours per day/7 days a week.
- Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs.
- Offers group therapy sessions with at least an **R.N.** or Masters-Level Health Professional.
- Has the ability to involve family/support systems in therapy (required for children and adolescents; encouraged for adults).
- Provides access to at least weekly sessions with a **Psychiatrist** or psychologist for individual psychotherapy.
- Has peer oriented activities.
- Services are managed by a licensed **Behavioral Health Provider** who, while not needing to be individually contracted, needs to (1) meet Our credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director).
- Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission.
- Provides a level of skilled intervention consistent with patient risk.
- Meets any and all applicable licensing standards established by the jurisdiction in which it is located.
- Is not a Wilderness Treatment Program or any such related or similar program, school and/or education service.

R.N.

A registered nurse.

Room and Board

Charges made by an institution for **room and board** and other **medically necessary** services and supplies. The charges must be regularly made at a daily or weekly rate.

S (GR-96782 34-095 10 VA)

Self-injectable Drug(s)

Prescription drugs that are intended to be self-administered by injection to a specific part of the body to treat medical conditions.

Semi-Private Room Rate

The **room and board** charge that an institution applies to the most beds in its semi-private rooms with 2 or more beds. If there are no such rooms, We will figure the rate based on the rate most commonly charged by similar institutions in the same geographic area.

Service Area

This is the geographic area, as determined by Us, in which **network providers** for this plan are located.

Skilled Nursing Facility

An institution that meets all of the following requirements:

- It is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from **illness** or **injury**:
 - Professional nursing care by an **R.N.**, or by a **L.P.N.** directed by a full-time **R.N.**; and
 - Physical restoration services to help patients to meet a goal of self-care in daily living activities.
- Provides 24 hour a day nursing care by licensed nurses directed by a full-time **R.N.**
- Is supervised full-time by a **physician** or an **R.N.**
- Keeps a complete medical record on each patient.
- Has a utilization review plan.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of individuals with non-biologically-based or biologically-based **mental illnesses**.
- Charges patients for its services.
- An institution or a distinct part of an institution that meets all of the following requirements:
 - It is licensed or approved under state or local law.
 - Is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.
- Qualifies as a **skilled nursing facility** under Medicare or as an institution accredited by:
 - The Joint Commission on Accreditation of Health Care Organizations;
 - The Bureau of **Hospitals** of the American Osteopathic Association; or
 - The Commission on the Accreditation of Rehabilitative Facilities

Skilled nursing facilities also include rehabilitation **hospitals** (all levels of care, e.g. acute) and portions of a **hospital** designated for skilled or **rehabilitation services**.

Skilled nursing facility does not include:

- Institutions which provide only:
 - Minimal care;
 - Custodial care services;
 - Ambulatory; or
 - Part-time care services.
- Institutions which primarily provide for the care and treatment of alcoholism, drug abuse or non-biologically-based or biologically-based **mental illnesses**.

Skilled Nursing Services

Services that meet all of the following requirements:

- The services require medical or paramedical training.
- The services are rendered by an **R.N.** or **L.P.N.** within the scope of his or her license.
- The services are not custodial.

Specialist

A **physician** who practices in any generally accepted medical or surgical sub-specialty.

Specialty Care

Health care services or supplies that require the services of a **specialist**.

Specialty Care Drugs

Injectable, infusion and oral **prescription drugs** that are prescribed to address complex, chronic diseases with associated co-morbidities such as cancer, rheumatoid arthritis, hemophilia, multiple sclerosis. You can access the list of these **specialty care prescription drugs** by calling the toll-free Member Services number on your Member ID card or by logging on to your Navigator® secure member website at www.Innovation-Health.com.

Specialty Pharmacy Network

A network of pharmacies designated to fill **specialty care drugs**.

Stay

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

Step Therapy

A form of **precertification** under which certain **prescription drugs** will be excluded from coverage, unless a first-line therapy drug(s) is used first by you. The list of step-therapy drugs is subject to change by Us or an affiliate. An updated copy of the list of drugs subject to **step therapy** shall be available upon request by you or may be accessed on Our website at www.aetnaspecialtyrx.com.

Substance Abuse

This is a physical or psychological dependency, or both, on a controlled substance or alcohol agent (These are defined on Axis I in the Diagnostic and Statistical Manual of **Mental Disorders** (DSM) published by the American Psychiatric Association which is current as of the date services are rendered to you or your covered dependents.) This term does not include conditions not attributable to a **mental illness** that are a focus of attention or treatment (the V codes on Axis I of DSM); an addiction to nicotine products, food or caffeine intoxication.

Surgery Center

A freestanding ambulatory surgical facility that meets all of the following requirements:

- Meets licensing standards.
- Is set up, equipped and run to provide general surgery.
- Charges for its services.
- Is directed by a staff of **physicians**. At least one of them must be on the premises when surgery is performed and during the recovery period.
- Has at least one certified anesthesiologist at the site when surgery requiring general or spinal anesthesia is performed and during the recovery period.
- Extends surgical staff privileges to:
 - **Physicians** who practice surgery in an area **hospital**; and
 - **Dentists** who perform oral surgery.
- Has at least 2 operating rooms and one recovery room.
- Provides, or arranges with a medical facility in the area for, diagnostic x-ray and lab services needed in connection with surgery.
- Does not have a place for patients to **stay** overnight.
- Provides, in the operating and recovery rooms, full-time **skilled nursing services** directed by an **R.N.**
- Is equipped and has trained staff to handle **emergency medical conditions**.

Must have all of the following:

- A **physician** trained in cardiopulmonary resuscitation; and
- A defibrillator; and
- A tracheotomy set; and
- A blood volume expander.
- Has a written agreement with a **hospital** in the area for immediate emergency transfer of patients.

- Written procedures for such a transfer must be displayed and the staff must be aware of them.
- Provides an ongoing quality assurance program. The program must include reviews by **physicians** who do not own or direct the facility.
- Keeps a medical record on each patient.

T

Telemedicine

Interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment with a **provider** that has contracted with Us to offer these services. Telemedicine services do not include an audio-only telephone, electronic mail message, or facsimile transmission.

Terminally Ill (Hospice Care)

Terminally ill means a medical prognosis of 12 months or less to live.

Therapeutic Drug Class

A group of drugs or medications that have a similar or identical mode of action or exhibit similar or identical outcomes for the treatment of a disease or **injury**.

U (GR-96782 34-105 02 V/A)

Urgent Admission

A **hospital** admission by a **physician** due to:

- The onset of or change in an **illness**; or
- The diagnosis of an **illness**; or
- An **injury**.
- The condition, while not needing an **emergency admission**, is severe enough to require confinement as an inpatient in a **hospital** within 2 weeks from the date the need for the confinement becomes apparent.

Urgent Care Facility

A facility licensed as a freestanding medical facility by applicable state and federal laws to treat an **urgent condition**.

Urgent Care Provider

This is:

- A freestanding medical facility that meets all of the following requirements.
 - Provides unscheduled medical services to treat an **urgent condition** if the person's **physician** is not reasonably available.
 - Routinely provides ongoing unscheduled medical services for more than 8 consecutive hours.
 - Makes charges.
 - Is licensed and certified as required by any state or federal law or regulation.
 - Keeps a medical record on each patient.
 - Provides an ongoing quality assurance program. This includes reviews by **physicians** other than those who own or direct the facility.
 - Is run by a staff of **physicians**. At least one **physician** must be on call at all times.
 - Has a full-time administrator who is a licensed **physician**.

- A **physician's** office, but only one that:
 - Has contracted with Us to provide urgent care; and
 - Is, with Our consent, included in the **directory** as a network **urgent care provider**.

It is not the emergency room or outpatient department of a **hospital**.

Urgent Condition

This means a sudden **illness; injury**; or condition; that:

- Is severe enough to require prompt medical attention to avoid serious deterioration of your health;
- Includes a condition which would subject you to severe pain that could not be adequately managed without urgent care or treatment;
- Does not require the level of care provided in the emergency room of a hospital; and
- Requires immediate outpatient medical care that cannot be postponed until your physician becomes reasonably available.

W (GR-96782 34-110 02)

Walk-in Clinic

Walk-in Clinics are free-standing health care facilities. They are an alternative to a **physician's** office visit for:

- treatment of unscheduled;
- non-emergency **illnesses**; and
- **Injuries**; and
- the administration of certain immunizations.

It is not an alternative for emergency room services or the ongoing care provided by a **physician**. Neither an emergency room, nor the outpatient department of a **hospital**, shall be considered a **Walk-in Clinic**.

Confidentiality Notice

Innovation Health considers personal information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. By "personal information," we mean information that relates to a member's physical or mental health or condition, the provision of health care to the member, or payment for the provision of health care or disability or life benefits to the member. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify the member.

When necessary or appropriate for your care or treatment, the operation of our health, disability or life insurance plans, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), payors (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your plan), other insurers, third party administrators, vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. In our health plans, participating network providers are also required to give you access to your medical records within a reasonable amount of time after you make a request.

Some of the ways in which personal information is used include claim payment; utilization review and management; medical necessity reviews; coordination of care and benefits; preventive health, early detection, vocational rehabilitation and disease and case management; quality assessment and improvement activities; auditing and anti-fraud activities; performance measurement and outcomes assessment; health, disability and life claims analysis and reporting; health services, disability and life research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. Innovation Health considers these activities key for the operation of our health, disability and life plans. To the extent permitted by law, we use and disclose personal information as provided above without member consent. However, we recognize that many members do not want to receive unsolicited marketing materials unrelated to their health, disability and life benefits. We do not disclose personal information for these marketing purposes unless the member consents. We also have policies addressing circumstances in which members are unable to give consent.

To obtain a copy of our Notice of Privacy Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please call the toll-free Member Services number on your ID card or visit our Internet site at www.innovation-health.com.

Additional Information Provided by

SAMPLE CO., INC.

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). It is not a part of your booklet-certificate. Your Plan Administrator has determined that this information together with the information contained in your booklet-certificate is the Summary Plan Description required by ERISA.

In furnishing this information, We are acting on behalf of your Plan Administrator who remains responsible for complying with the ERISA reporting rules and regulations on a timely and accurate basis.

Name of Plan:

SAMPLE CO., INC. Health & Welfare Plan

Employer Identification Number:

SAMPLE

Plan Number:

SAMPLE

Type of Plan:

Welfare

Type of Administration:

Group Insurance Policy with:

Innovation Health Insurance Company
3190 Fairview Park Drive
5th Floor Suite 570
Falls Church, VA 22042

Plan Administrator:

SAMPLE

SAMPLE

SAMPLE

SAMPLE

Telephone Number: SAMPLE

Agent For Service of Legal Process:

SAMPLE

SAMPLE

SAMPLE

SAMPLE

Service of legal process may also be made upon the Plan Administrator

End of Plan Year:

SAMPLE

Source of Contributions:

SAMPLE

Procedure for Amending the Plan:

The Employer may amend the Plan from time to time by a written instrument signed by the person designated by the Plan Administrator.

ERISA Rights

As a participant in the group insurance plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), and an updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Receive a copy of the procedures used by the Plan for determining a qualified domestic relations order (QDRO) or a qualified medical child support order (QMCSO).

Continue Group Health Plan Coverage

Continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to preexisting condition exclusion for 12 months after your enrollment date in your coverage under this Plan. Contact your Plan Administrator for assistance in obtaining a certificate of creditable coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in your interest and that of other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to \$ 110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the status of a domestic relations order or a medical child support order, you may file suit in a federal court.

If it should happen that plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, you should contact:

- the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or
- the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that you, your physician, or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain precertification for any days of confinement that exceed 48 hours (or 96 hours). For information on precertification, contact your plan administrator.

Notice Regarding Women's Health and Cancer Rights Act

Under this health plan, as required by the Women's Health and Cancer Rights Act of 1998, coverage will be provided to a person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy for:

- (1) all stages of reconstruction of the breast on which a mastectomy has been performed;
- (2) surgery and reconstruction of the other breast to produce a symmetrical appearance;
- (3) prostheses; and
- (4) treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be provided in accordance with the plan design, limitations, copays, deductibles, and referral requirements, if any, as outlined in your plan documents.

If you have any questions about our coverage of mastectomies and reconstructive surgery, please contact the Member Services number on your ID card.

For more information, you can visit this U.S. Department of Health and Human Services website, <http://www.cms.gov/home/regsguidance.asp>, and this U.S. Department of Labor website, http://www.dol.gov/ebsa/consumer_info_health.html.

IMPORTANT HEALTH CARE REFORM NOTICES

CHOICE OF PROVIDER

If your plan generally requires or allows the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If the plan or health insurance coverage designates a primary care provider automatically, then until you make this designation, Innovation Health designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your Employer or, if you are a current member, your contact number on the back of your ID card.

If your plan allows for the designation of a primary care provider for a child, you may designate a pediatrician as the primary care provider.

If your plan provides coverage for obstetric or gynecological care and requires the designation of a primary care provider then you do not need prior authorization from Us or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your Employer or, if you are a current member, your contact number on the back of your ID card.

IMPORTANT HEALTH CARE REFORM INFORMATION

Some language changes in response to the federal Affordable Care Act (ACA) may not be included in the enclosed certificate of coverage. This may be because the language is still pending regulatory review and approval. However, please note that for new plans on or after January 1, 2014, and for non-grandfathered plans that renew on a date on or after January 1, 2014, Innovation Health is administering medical and outpatient prescription drug coverage in compliance with the following applicable components of the ACA.

The following is a summary of the recent changes under the ACA.

For details on any benefit maximums and the cost sharing under your plan, log onto the website www.innovation-health.com, call the Member Services number on the back of your ID card, or refer to the Summary of Benefit and Coverage document you have received.

1. Subject to any allowed applicable age, family history and frequency guidelines for preventive services covered under the plan, (which may be in-network only for plans that use a provider network) the following services are included in those considered preventive:
 - Coverage of comprehensive lactation support and counseling, and the costs of renting or purchasing breastfeeding equipment extended for the duration of breastfeeding.
 - In accordance with the recommendations of the United States Preventive Services Task Force, and when prescribed by a physician:
 - i. aspirin for men and women age 45 and over;
 - ii. folic acid for women planning or capable of pregnancy;
 - iii. routine iron supplementation for asymptomatic children ages 6 to 12 months;
 - iv. vitamin D supplementation for men and women age 65 and older;
 - v. fluoride supplementation for children from age 6 months through age 5;
 - vi. genetic counseling, evaluation and lab tests for routine breast cancer susceptibility gene (BRCA) testing;
 - vii. Food and Drug Administration (FDA) approved female over-the-counter contraceptives, and an office visit for contraceptive administration and/or removal of a contraceptive device
2. The medical in-network out-of-pocket maximum for a plan that does use a provider network , and the out-of-pocket maximums for a plan that does not use a provider network - cannot exceed \$6,350 per person and \$12,700 per family for your 2014 plan year. If your medical plan is packaged with a plan that covers outpatient prescription drugs, the outpatient prescription drug plan may:
 - a. not include out-of-pocket maximums; or
 - b. have separate maximums from the medical plan up to these same amounts; or
 - c. have maximums that are combined with the medical plan up to these same amounts.
3. Any annual or lifetime dollar maximum benefit that applies to "Essential Health Benefits" (as defined by the ACA and included in the plan) no longer applies. Essential Health Benefits will continue to be subject to any coinsurance, copays, deductibles, other types of maximums (e.g., day and visit maximums), referral and certification rules, and any exclusions and limitations that apply to these types of covered medical expenses under your plan.
4. If your Plan includes a pre-existing condition limitation or exclusion provision, including one that may apply to transplant coverage, then this limitation or exclusion no longer applies.
5. If your Plan includes a waiting or probationary period, (the period of time that must pass before your coverage can become effective), this period of time cannot be greater than 90 days.

Continuation of Coverage During an Approved Leave of Absence Granted to Comply With Federal Law

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by Family and Medical Leave Act of 1993 (FMLA). If your Employer grants you an approved FMLA leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be subject to prior written agreement between Innovation Health and your Employer.

If your Employer grants you an approved FMLA leave in accordance with FMLA, you may, during the continuance of such approved FMLA leave, continue Health Expense Benefits for you and your eligible dependents.

At the time you request the leave, you must agree to make any contributions required by your Employer to continue coverage. Your Employer must continue to make premium payments.

If Health Expense Benefits has reduction rules applicable by reason of age or retirement, Health Expense Benefits will be subject to such rules while you are on FMLA leave.

Coverage will not be continued beyond the first to occur of:

- The date you are required to make any contribution and you fail to do so.
- The date your Employer determines your approved FMLA leave is terminated.
- The date the coverage involved discontinues as to your eligible class. However, coverage for health expenses may be available to you under another plan sponsored by your Employer.

Any coverage being continued for a dependent will not be continued beyond the date it would otherwise terminate.

If Health Expense Benefits terminate because your approved FMLA leave is deemed terminated by your Employer, you may, on the date of such termination, be eligible for Continuation Under Federal Law on the same terms as though your employment terminated, other than for gross misconduct, on such date. If the group contract provides any other continuation of coverage (for example, upon termination of employment, death, divorce or ceasing to be a defined dependent), you (or your eligible dependents) may be eligible for such continuation on the date your Employer determines your approved FMLA leave is terminated or the date of the event for which the continuation is available.

If you acquire a new dependent while your coverage is continued during an approved FMLA leave, the dependent will be eligible for the continued coverage on the same terms as would be applicable if you were actively at work, not on an approved FMLA leave.

If you return to work for your Employer following the date your Employer determines the approved FMLA leave is terminated, your coverage under the group contract will be in force as though you had continued in active employment rather than going on an approved FMLA leave provided you make request for such coverage within 31 days of the date your Employer determines the approved FMLA leave to be terminated. If you do not make such request within 31 days, coverage will again be effective under the group contract only if and when Innovation Health gives its written consent.

If any coverage being continued terminates because your Employer determines the approved FMLA leave is terminated, any Conversion Privilege will be available on the same terms as though your employment had terminated on the date your Employer determines the approved FMLA leave is terminated.

Schedule of Benefits

(GR-96782 S-01-01 02 V/A)

Employer: SAMPLE CO., INC.

Group Policy Number: IHGP-SAMPLE

Issue Date: SAMPLE
Effective Date: January 1, 2018
Schedule: SAMPLE-A
Cert Base: SAMPLE

For: PPO Medical - 100/80 Plan

This is an ERISA plan, and you have certain rights under this plan. Please contact your Employer for additional information.

Important Note

If you receive services from an **out-of-network provider**, We may reimburse you directly for those services. If this happens, you are responsible for applying that payment toward your **out-of-network provider** bill.

PPO Medical Plan (GR-96782 S-10-05 04 V/A)

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Calendar Year Deductible*		
Individual Deductible*	None	\$300
Family Deductible*	None	\$600

*Unless otherwise indicated, any applicable **deductible** must be met before benefits are paid.

Plan Maximum Out of Pocket Limit includes plan **deductible** and **copayments**.

Plan Maximum Out of Pocket Limit excludes **precertification** penalties.

Individual Maximum Out of Pocket Limit:

- For **network** expenses: \$1,000.
- For **out-of-network** expenses: \$2,000.

Family Maximum Out of Pocket Limit:

- For **network** expenses: \$2,000.
- For **out-of-network** expenses: \$4,000.

Coinsurance listed in the Schedule below reflects the Plan Coinsurance. This is the amount We pay. You are responsible to pay any deductibles and the remaining coinsurance. You are responsible for full payment of any non-covered expenses you incur.

All Covered Expenses Are Subject To The Calendar Year Deductible Unless Otherwise Noted In The Schedule Below.

Maximums for specific covered expenses, including visit, day and dollar maximums are combined maximums between network and out-of-network and other health care, unless specifically stated otherwise.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Preventive Care Benefits (GR-96782 S-10-16 02 VA)</i>		
<i>Routine Physical Exams</i>		
<i>Office Visits</i>		
<i>Covered Persons through age 21</i>	100% per visit	100% per visit
	No copay or deductible applies.	No copay or deductible applies.
<i>Covered persons age 22 and over</i>	100% per visit	80% per visit after Plan Year deductible
	No copay or deductible applies.	
<i>Covered Persons through age 21: Maximum Age & Visit Limits</i>	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. <i>For details, contact your physician, log onto the website www.innovation-health.com, or call the number on the back of your ID card.</i>	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. <i>For details, contact your physician, log onto the website www.innovation-health.com, or call the number on the back of your ID card.</i>
<i>Covered Persons ages 22 but less than 65: Maximum Visits per Calendar Year</i>	1 visit	1 visit
<i>Covered Persons age 65 and over: Maximum Visits per Calendar Year</i>	1 visit	1 visit
<i>Preventive Care Immunizations</i> (GR-96782 S-10-16 02 VA)		
<i>Performed in a facility or physician's</i>		

<i>office</i> Covered Persons through age 21	100% per visit No copay or deductible applies.	100% per visit No copay or deductible applies.
Covered persons age 22 and over	100% per visit No copay or deductible applies. Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. <i>For details, contact your physician, log onto our website www.innovation-health.com or call the number on the back of your ID card</i>	80% per visit. No deductible applies Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. <i>For details, contact your physician, log onto our website www.innovation-health.com or call the number on the back of your ID card</i>
Screening & Counseling Services (GR-96782 S-10-16 02 V.A) Office Visit Obesity, Misuse of Alcohol and/or Drugs & Use of Tobacco Products	100% per visit No copay or deductible applies.	80% per visit after Calendar Year deductible
<i>Obesity</i> (GR-96782 S-10-16 02 V.A) Maximum Visits per 12 consecutive months <i>(This maximum applies only to Covered Persons ages 22 & older.)</i>	26 visits <i>(however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*</i>	26 visits <i>(however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*</i>
*Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.		
<i>Misuse of Alcohol and/or Drugs</i> (GR-96782 S-10-16 02 V.A)	5 visits*	5 visits*
Maximum Visits per 12 consecutive months		
*Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.		
Use of Tobacco Products (GR-96782 S-10-16 02 V.A)		

Maximum Visits per 12 consecutive months	8 visits*	8 visits*
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***Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.**

Well Woman Preventive Visits (GR-96782 S-10-16 02 V.A)		
Office Visits	100% per visit	80% per visit after Calendar Year deductible
	No copay or Calendar Year deductible applies.	

Maximum Visits per Calendar Year	1 visit	1 visit
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Routine Cancer Screenings (GR-96782 S-10-16 02 V.A)		
Outpatient: Baseline Mammogram and PSA tests for person at high risk age 40 and over.	100% per visit No Calendar Year deductible applies.	80% per visit after Calendar Year deductible
Maximum for Baseline Mammogram	One baseline mammogram for women age 35 but less than age 40.	One baseline mammogram for women age 35 but less than age 40.
Outpatient: All Other Routine Cancer Screenings	100% per visit No copay or Calendar Year deductible applies.	80% per visit after Calendar Year deductible

Maximums (GR-96782 S-10-16 02 V.A)	<p>Subject to any age; family history; and frequency guidelines as set forth in the most current:</p> <ul style="list-style-type: none"> ■ 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; and ■ the comprehensive guidelines supported by the Health Resources and Services Administration. <p>For details, contact your physician, log onto our website www.innovation-health.com, or call the number on the back of your ID card.</p>	<p>Subject to any age; family history; and frequency guidelines as set forth in the most current:</p> <ul style="list-style-type: none"> ■ 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; and ■ the comprehensive guidelines supported by the Health Resources and Services Administration. <p>For details, contact your physician, log onto our website www.innovation-health.com, or call the number on the back of your ID card.</p>
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Prenatal Care (GR-96782 S-10-16 02 V/A)**Office Visits**

100% per visit

80% per visit after Calendar Year
deductible.No copay or Calendar Year
deductible applies.

Important Note: Refer to the *Physician Services* and *Pregnancy Expenses* sections of the *Schedule of Benefits* for more information on coverage levels for pregnancy expenses under this Plan, including other prenatal care, delivery and postnatal care office visits.

Lactation Counseling Services -
Facility or Office Visits

100% per visit

80% per visit after Calendar Year
deductibleNo copay or Calendar Year
deductible applies

Lactation Counseling Services
Maximum Visits per Calendar Year
either in a group or individual
setting

6* visits

6* visits

***Important Note:** Visits in excess of the Lactation Counseling Maximum as shown above, are covered under the *Physician Services* office visit section of the *Schedule of Benefits*.

Breast Pumps & Supplies

(GR-96782 S-10-16 02 V/A)

100% per item.

80% per item after Calendar Year
deductibleNo copay or Calendar Year
deductible applies.

Important Note: Refer to the *Comprehensive Lactation Support and Counseling Services* section of the Booklet-Certificate for limitations on breast pumps and supplies.

Family Planning Services – Female Contraceptives (GR-96782 S-10-16 02 V/A)Female Contraceptive Counseling
Services -Office Visits.

100% per visit.

80% per visit after Calendar Year
deductible.No **copay** or Calendar Year
deductible applies.

Contraceptive Counseling Services -
Maximum Visits per 12 months
either in a group or individual
setting

2* visits

2* visits

*Important Note: Visits in excess of the Contraceptive Counseling Services Maximum as shown above, are covered under the *Physician Services* office visit section of the *Schedule of Benefits*.

Family Planning Services - Female Voluntary Sterilization (GR-96782 S-10-16 02 V/A)

Inpatient	100% per admission. No copay or Calendar Year deductible applies.	80% per admission after Calendar Year deductible
Outpatient	100% per visit/surgical procedure. No copay or Calendar Year deductible applies.	80% per visit/surgical procedure after Calendar Year deductible

PLAN FEATURES**PLAN COINSURANCE****Family Planning Services - Female Contraceptives** (GR-96782 S-10-16 02 V/A)

Female Contraceptive Generic Prescription Drugs	100% per prescription or refill No Calendar Year deductible applies.
Female Contraceptive Devices	100% per prescription or refill No Calendar Year deductible applies.

Important Note:

Refer to the *Outpatient Prescription Drug Expenses* section of your *Schedule of Benefits* for more information on other prescription drug coverage under this Plan.

Family Planning Services – Other (GR-96782 S-10-17 01 V/A)

Voluntary Sterilization for Males Outpatient	100% per visit/surgical procedure. No Calendar Year deductible applies	80% per visit/surgical procedure after Calendar Year deductible .
Voluntary Termination of Pregnancy Outpatient	100% per visit/surgical procedure. No Calendar Year deductible applies.	80% per visit/surgical procedure after Calendar Year deductible .

PLAN FEATURES**NETWORK****OUT-OF-NETWORK****Vision Care** (GR-96782 S-10-21 01 V/A)

Eye Examinations (including refraction)	100% per exam No Calendar Year deductible applies.	80% per exam after Calendar Year deductible
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Maximum Benefit per 24 consecutive month period	1 exam	1 exam
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Physician Services (GR-96782 S-10-25 09 VA)		
Physicians and Specialists Office Visits (<i>non-surgical</i>)		
<i>This includes non-surgical visits to a physician or specialist, Telemedicine online consultation, and Walk-in clinic non-emergency visit.</i>		
Physician Office Visits (<i>non-surgical</i>)	\$10 visit copay then the plan pays 100%	80% per visit after Calendar Year deductible
	No Calendar Year deductible applies.	

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Specialist Office Visits	\$10 per visit copay then the plan pays 100%	80% per visit after Calendar Year deductible
	No Calendar Year deductible applies.	

Physician Office Visits-Surgery	100% per visit	80% per visit after Calendar Year deductible
	No Calendar Year deductible applies.	

Alternative to Physician Office Visit (GR-96782 S-10-25 09)		
Walk-In Clinic Visit (Non-Emergency)		
Preventive Care Services*		
Immunizations	100% per visit	80% per visit after Calendar Year deductible
	No copay or deductible applies.	
	For details, contact your physician , log onto our website www.innovation-health.com , or call the number on the back of your ID card.	
Individual Screening and Counseling Services for Tobacco Use	100% per visit	80% per visit after Calendar Year deductible
	No copay or deductible applies.	
Maximum Benefit per visit -	Refer to the <i>Preventive Care Benefit</i>	Refer to the Preventive Care Benefit

Individual Screening and Counseling Services for Tobacco Use	section earlier in this Schedule of Benefits for maximums that may apply to these types of services	section earlier in this Schedule of Benefits for maximums that may apply to these types of services
Individual Screening and Counseling Services for Obesity	100% per visit No copay or deductible applies.	80% per visit after Calendar Year deductible
Maximum Benefit per visit - Individual Screening and Counseling Services for Obesity	Refer to the <i>Preventive Care Benefit</i> section earlier in this Schedule of Benefits for maximums that may apply to these types of services	Refer to the Preventive Care Benefit section earlier in this Schedule of Benefits for maximums that may apply to these types of services
*Important Note: Not all preventive care services are available at all Walk-In Clinics . The types of services offered will vary by the provider and location of the clinic. These services may also be obtained from your physician .		
<i>All Other Services</i>	\$10 visit copay then the plan pays 100% No Calendar Year deductible applies	80% per visit after Calendar Year deductible

<i>Administration of Anesthesia</i>	100% per procedure No Calendar Year deductible applies	80% per procedure after Calendar Year deductible
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<i>Allergy Injections</i>	100% per visit No Calendar Year deductible applies.	80% per visit after Calendar Year deductible
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Emergency Medical Services</i> (GR-96782 S-10-30 04 V/A)		
<i>Hospital Emergency Facility and Physician</i>	\$50 copay per visit then the plan pays 100% No Calendar Year deductible applies.	\$50 deductible per visit then the plan pays 100% No Calendar Year deductible applies. See Important Note Below
Important Note: Please note that as these providers are not network providers and do not have a contract with Us, the provider may not accept payment of your cost share (your deductible and coinsurance), 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 Emergency Room Facility or physician bills you for an amount above your cost share, you are not responsible for paying that amount. Please send us the bill at the address listed your member ID card and we will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.		

<i>Non-Emergency Care in a Hospital Emergency Room</i>	Not covered	Not covered
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<i>Urgent Care Services</i>		
<i>Urgent Medical Care</i> <i>(at a non-hospital free standing facility)</i>	\$35 copay per visit then the plan pays 100%	80% after Calendar Year deductible
	No Calendar Year deductible applies.	

<i>Urgent Medical Care</i> <i>(from other than a non-hospital free standing facility)</i>	Refer to <i>Emergency Medical Services</i> and <i>Physician Services</i> above.	Refer to <i>Emergency Medical Services</i> and <i>Physician Services</i> above.
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<i>Non-Urgent Use of Urgent Care Provider</i> <i>(at an Emergency Room or a non-hospital free standing facility)</i>	Not covered	Not covered
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PLAN FEATURES

Outpatient Diagnostic and Preoperative Testing (GR-96782 S-10-35 04 V.A)

<i>Complex Imaging Services</i>		
<i>Complex Imaging</i>	90% per test	70% per test after Calendar Year deductible
	No Calendar Year deductible applies	

<i>Diagnostic Laboratory Testing</i>		
<i>Diagnostic Laboratory Testing</i>	100% per procedure	80% per procedure after Calendar Year deductible
	No Calendar Year deductible applies.	

<i>Diagnostic X-Rays</i>		
<i>Diagnostic X-Rays</i>	100% per procedure No Calendar Year deductible applies.	80% per procedure after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Outpatient Surgery</i> (GR-96782 S-10-40 06 VA)		
<i>Outpatient Surgery</i>	100% per visit/surgical procedure No Calendar Year deductible applies	80% per visit/surgical procedure after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Inpatient Facility Expenses</i> (GR-96782 S-10-45 06 VA)		
<i>Birth Center</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

<i>Hospital Facility Expenses</i>		
Room and Board (including maternity)	100% per admission No Calendar Year deductible applies	80% per admission after Calendar Year deductible
Other than Room and Board	100% per admission No Calendar Year deductible applies	80% per admission after Calendar Year deductible

<i>Skilled Nursing Inpatient Facility</i>	100% per admission No Calendar Year deductible applies	80% per admission after Calendar Year deductible
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Maximum Days per Calendar Year	60 days	60 days
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Specialty Benefits (GR-96782 S-10-50 06 V.A)		
Home Health Care (Outpatient)	100% per visit No Calendar Year deductible applies.	80% per visit after Calendar Year deductible

Maximum Visits per Calendar Year	100 visits	100 visits
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Skilled Nursing Care (Outpatient)	100% per visit No Calendar Year deductible applies	80% per visit after the Calendar Year deductible
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Hospice Benefits		
Hospice Care - Facility Expenses (Room & Board)	100% per admission No Calendar Year deductible applies	80% per admission after Calendar Year deductible
Hospice Care - Other Expenses during a stay	100% per admission No Calendar Year deductible applies	80% per admission after Calendar Year deductible

Maximum Benefit per lifetime	Unlimited days	Unlimited days
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Hospice Outpatient Visits	100% per visit No Calendar Year deductible applies.	80% per visit after Calendar Year deductible
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Infertility Treatment (GR-96782 S-10-55 03 V.A)		
Basic Infertility Expenses Coverage is for the diagnosis and treatment of the underlying medical condition causing the infertility only.	Payable in accordance with type of expense incurred. Refer to the Physician Services and other sections of this Schedule to determine what the plan pays.	Payable in accordance with type of expense incurred. Refer to the Physician Services and other sections of this Schedule to determine what the plan pays.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Inpatient Treatment of Mental Disorders</i> (GR-96782 S-10-62 02 V/A)		

MENTAL DISORDERS

Hospital Facility Expenses

Room and Board	100% per admission No Calendar Year deductible applies.	80% per admission after Calendar Year deductible
Other than Room and Board	100% per admission No Calendar Year deductible applies.	80% per admission after Calendar Year deductible
Physician Services	100% per admission No Calendar Year deductible applies.	80% per admission after Calendar Year deductible

<i>Inpatient Residential Treatment Facility Expenses</i>	100% per admission No Calendar Year deductible applies.	80% per admission after Calendar Year deductible
<i>Inpatient Residential Treatment Facility Expenses Physician Services</i>	100% per visit No Calendar Year deductible applies.	80% per visit after Calendar Year deductible

Outpatient Treatment Of Mental Disorders

Outpatient Services	\$10 per visit copay then the plan pays 100%	80% per visit after the Calendar Year deductible
	No Calendar Year deductible applies.	

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Treatment of Substance Abuse		
Hospital Facility Expenses	100% per admission	80% per admission after Calendar Year deductible
Room and Board	No Calendar Year deductible applies	
Other than Room and Board	100% per admission	80% per admission after Calendar Year deductible
	No Calendar Year deductible applies.	
Physician Services	100% per admission	80% per admission after Calendar Year deductible
	No Calendar Year deductible applies.	

Inpatient Residential Treatment Facility Expenses	100% per admission	80% per admission after Calendar Year deductible
	No Calendar Year deductible applies.	
Inpatient Residential Treatment Facility Expenses Physician Services	100% per visit	80% per visit after Calendar Year deductible
	No Calendar Year deductible applies.	

Outpatient Treatment of Substance Abuse		
Outpatient Treatment	\$10 per visit copay then the plan pays 100%	80% per visit after Calendar Year deductible
	No Calendar Year deductible applies.	

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Obesity Treatment Surgical and Non Surgical		
Outpatient Obesity Treatment	100% per visit	80% per visit after Calendar Year

<i>(non surgical)</i>	No Calendar Year deductible applies	deductible
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<i>Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services)</i>	100% per admission No Calendar Year deductible applies	80% per admission after Calendar Year deductible
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PLAN FEATURES	NETWORK (IOE Facility)	NETWORK (Non-IOE Facility)	OUT-OF- NETWORK
<i>Transplant Services Facility and Non-Facility Expenses</i> (GR-96782 S-10-75 04 V.A)			
<i>Transplant Facility Expenses</i>	100% per admission No Calendar Year deductible applies.	80% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible
Transplant Physician Services (including office visits)	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided

PLAN FEATURES
<i>Other Covered Health Expenses</i> (GR-96782 S-10-80 05 V.A)

<i>Acupuncture in lieu of anesthesia</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
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<i>Ground, Air or Water Ambulance</i>	100% No Calendar Year deductible applies	100% No Calendar Year deductible applies
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<i>Diabetic Equipment, Supplies and Education</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
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<i>Durable Medical and Surgical Equipment and Supplies</i>	50% per item No Calendar Year deductible applies	50% per item after Calendar Year deductible						
<i>Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.						
<i>Prosthetic Devices</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.						
<table> <tr> <th>PLAN FEATURES</th><th>NETWORK</th><th>OUT-OF-NETWORK</th></tr> <tr> <td colspan="3"><i>Outpatient Therapies</i> (GR-96782 S-10-90 04 V/A)</td></tr> </table>			PLAN FEATURES	NETWORK	OUT-OF-NETWORK	<i>Outpatient Therapies</i> (GR-96782 S-10-90 04 V/A)		
PLAN FEATURES	NETWORK	OUT-OF-NETWORK						
<i>Outpatient Therapies</i> (GR-96782 S-10-90 04 V/A)								
<i>Chemotherapy</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.						
<i>Infusion Therapy</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.						
<i>Radiation Therapy</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.						
<table> <tr> <th>PLAN FEATURES</th><th>NETWORK</th><th>OUT-OF-NETWORK</th></tr> <tr> <td colspan="3"><i>Short Term Outpatient Rehabilitation Therapies</i> (GR-96782 S-10-95 07 V/A)</td></tr> </table>			PLAN FEATURES	NETWORK	OUT-OF-NETWORK	<i>Short Term Outpatient Rehabilitation Therapies</i> (GR-96782 S-10-95 07 V/A)		
PLAN FEATURES	NETWORK	OUT-OF-NETWORK						
<i>Short Term Outpatient Rehabilitation Therapies</i> (GR-96782 S-10-95 07 V/A)								
<i>Outpatient Physical, Occupational, and Speech Therapy combined</i>	\$10 per visit copay then the plan pays 100% No Calendar Year deductible applies	80% per visit after Calendar Year deductible						

Combined Physical, Occupational and Speech Therapy Maximum visits per Calendar Year	60 visits	60 visits
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Spinal Manipulation</i> (GR-96782 S-10-95 07 V/A)		
<i>Spinal Manipulation</i>	\$10 per visit copay then the plan pays 100% No Calendar Year deductible applies.	80% per visit after Calendar Year deductible

Spinal Manipulation Maximum visits per Calendar Year	20 visits	20 visits
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Autism Spectrum Disorder</i> (GR-96782 S-10-61 03 V/A)		
	Cost sharing is based upon the type of service or supply provided and the place where the service or supply is rendered.	Cost sharing is based upon the type of service or supply provided and the place where the service or supply is rendered.
Maximum benefit per calendar year for Applied Behavioral Analysis	\$35,000	\$35,000

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Other Services</i> (GR-96782 S-10-61 03 V/A)		
<i>General Anesthesia for Dental Care</i>	Payable in accordance with the type of expense incurred. Refer to the appropriate sections of this Schedule to determine what the plan pays.	Payable in accordance with the type of expense incurred. Refer to the appropriate sections of this Schedule to determine what the plan pays.
<i>Infant Hearing Screening Expenses</i>	Payable in accordance with the type of expense incurred. Refer to the appropriate sections of this Schedule to determine what the plan pays.	Payable in accordance with the type of expense incurred. Refer to the appropriate sections of this Schedule to determine what the plan pays.
<i>Bones or Joints of the Head, Neck, Face or Jaw Expenses</i>	Payable in accordance with the type of expense incurred. Refer to the appropriate sections of this Schedule to determine what the plan pays.	Payable in accordance with the type of expense incurred. Refer to the appropriate sections of this Schedule to determine what the plan pays.
<i>Blood Products and Blood Infusion Equipment Expenses</i>	Payable in accordance with the type of expense incurred. Refer to the appropriate sections of this Schedule	Payable in accordance with the type of expense incurred. Refer to the appropriate sections of this Schedule

	to determine what the plan pays.	to determine what the plan pays.
<i>Reconstructive Breast Surgery Expenses</i>	Payable in accordance with the type of expense incurred. Refer to the appropriate sections of this Schedule to determine what the plan pays.	Payable in accordance with the type of expense incurred. Refer to the appropriate sections of this Schedule to determine what the plan pays.
<i>Mastectomy and Hysterectomy Expenses</i>	Payable in accordance with the type of expense incurred. Refer to the appropriate sections of this Schedule to determine what the plan pays.	Payable in accordance with the type of expense incurred. Refer to the appropriate sections of this Schedule to determine what the plan pays.
<i>Treatment of Lymphedema</i>	Payable in accordance with the type of expense incurred. Refer to the appropriate sections of this Summary to determine what the plan pays.	Payable in accordance with the type of expense incurred. Refer to the appropriate sections of this Summary to determine what the plan pays.
<i>Early Intervention Services</i>	Payable in accordance with the type of expense incurred. Refer to the appropriate sections of this Schedule to determine what the plan pays.	Payable in accordance with the type of expense incurred. Refer to the appropriate sections of this Schedule to determine what the plan pays.
<i>Cancer Clinical Trial Expenses</i>	Payable in accordance with the type of expense incurred. Refer to the appropriate sections of this Schedule to determine what the plan pays.	Payable in accordance with the type of expense incurred. Refer to the appropriate sections of this Schedule to determine what the plan pays.
<i>Child Health Supervision Services</i>	These services are exempt from any copayment, coinsurance, deductible or any other dollar limit provision of this plan.	These services are exempt from any copayment, coinsurance, deductible or any other dollar limit provision of this plan.

Pharmacy Benefit (GR-96782 S-26-005 01 V.A)

Copays/Deductibles (GR-96782 S-26-011 03 V.A) (GR-96782 S-26-013 03 V.A) (GR-96782 S-26-016 03 V.A)

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK	OUT-OF-NETWORK
<i>Preferred Generic Prescription Drugs</i>		
For each initial 30 day supply filled at a retail pharmacy	\$10	\$10
For all fills for at least a 31 day supply and up to a 90 day supply filled at a mail order pharmacy	\$20	Not Applicable

<i>Preferred Brand-Name Prescription Drugs</i>		
For each initial 30 day supply filled at a retail pharmacy	\$20	\$20
For all fills for at least a 31 day supply and up to a 90 day supply filled at a mail order pharmacy	\$40	Not Applicable

<i>Non-Preferred Generic Prescription Drugs</i>		
For each initial 30 day supply filled at a retail pharmacy	\$10	\$10
For all fills for at least a 31 day supply and up to a 90 day supply filled at a mail order pharmacy	\$20	Not Applicable

<i>Non-Preferred Brand-Name Prescription Drugs</i>		
For each initial 30 day supply filled at a retail pharmacy	\$35	\$35
For all fills for at least a 31 day supply and up to a 90 day supply filled at a mail order pharmacy	\$70	Not Applicable

<i>Specialty Care Prescription Drugs</i>		
For each 30 day supply	20% of the negotiated charge not to exceed \$150	Not Covered

If you or your **prescriber** request a covered **brand-name prescription drug** when a covered **generic prescription drug** equivalent is available, you will be responsible for the cost difference between the **generic prescription drug** and the **brand-name prescription drug**, plus the applicable cost sharing.

Coinsurance

	NETWORK	OUT-OF-NETWORK
Prescription Drug Plan Coinsurance	100% of the negotiated charge	70% of the recognized charge

The **prescription drug plan coinsurance** is the percentage of **prescription drug covered expenses** that the plan pays after any applicable **deductibles** and **copays** have been met.

Precertification and **step therapy** for certain **prescription drugs** is required. If **precertification** is not obtained, the **prescription drug** will not be covered.

Expense Provisions (GR-96872 S-09-05 04 V/A)

The following provisions apply to your health expense plan.

This section describes cost sharing features, benefit maximums and other important provisions that apply to your Plan. The specific cost sharing features and the applicable dollar amounts or benefit percentages are contained in the attached health expense sections of this *Schedule of Benefits*.

The insurance described in this *Schedule of Benefits* will be provided under Our policy form GR-96781.

Keep This Schedule of Benefits With Your Booklet-Certificate.

Deductible Provisions (GR-96782 S-09-05 04 V/A)

Covered expenses applied to the **out-of-network provider deductibles** will not be applied to satisfy the **network provider deductibles**. **Covered expenses** applied to the **network provider deductibles** will not be applied to satisfy the **out-of-network provider deductibles**.

All **covered expenses** accumulate toward the **network provider and out-of-network provider deductibles** except for those **covered expenses** identified later in this *Schedule of Benefits*.

You and each of your covered dependents have separate Calendar Year **deductibles**. Each of you must meet your **deductible** separately and they cannot be combined. This Plan has individual and family Calendar Year **deductibles**.

Out-of-Network Provider Calendar Year Deductible

Individual

This is the amount of **covered expenses** that you and each of your covered dependents incur each Calendar Year from an **out-of-network provider** for which no benefits will be paid. This individual Calendar Year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach this individual Calendar Year **deductible**; this Plan will begin to pay benefits for **covered expenses** that you incur from an **out-of-network provider** for the rest of the Calendar Year.

Family Deductible Limit

When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **deductibles**, these expenses will also count toward a family **deductible** limit.

To satisfy this family **deductible** limit for the rest of the Calendar Year, the following must happen:

The combined **covered expenses** that you and each of your covered dependents incur towards the individual Calendar Year **deductibles** must reach this family **deductible** limit in a Calendar Year.

When this occurs in a Calendar Year, the individual Calendar Year **deductibles** for you and your covered dependents will be considered to be met for the rest of the Calendar Year.

Copayment, Copay

This is a specified dollar amount or percentage, shown in the *Schedule of Benefits*, you are required to pay for **covered expenses**.

Coinsurance Provisions (GR-96782 S-09-20 04 V/A)

Coinsurance

This is the percentage of your **covered expenses** that the plan pays and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as the “**Plan Coinsurance**”. Once applicable **deductibles** have been met, your plan will pay a percentage of the **covered expenses**, and you will be responsible for the rest of the costs. The **coinsurance** percentage may vary by the type of expense. Refer to your *Schedule of Benefits* for coinsurance amounts for each covered benefit.

Maximum Out of Pocket Limit

The **Maximum Out of Pocket Limit** is the maximum amount you are responsible to pay for **covered expenses** during the Calendar Year. This Plan has an individual **Maximum Out of Pocket Limit**. As to the individual **Maximum Out of Pocket Limit**, each of you must meet your **Maximum Out of Pocket Limit** separately and they cannot be combined and applied towards one limit.

Certain **covered expenses** do not apply toward the **Maximum Out of Pocket Limit**. See list below.

Network Provider Maximum Out of Pocket Limit

Individual

Once the amount of eligible **network provider** expenses you or your covered dependents have paid during the Calendar Year meets the individual **Maximum Out of Pocket Limit**, this Plan will pay 100% of such **covered expenses** that apply toward the limit for the remainder of the Calendar Year for that person.

Family Maximum Out of Pocket Limit

When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **network provider Maximum Out of Pocket Limit**, these expenses will also count toward a family **network provider Maximum Out of Pocket Limit**.

To satisfy this family **network provider Maximum Out of Pocket Limit** for the rest of the Calendar Year, the following must happen:

The family **Maximum Out of Pocket Limit** is a cumulative **Maximum Out of Pocket Limit** for all family members. The family **network provider Maximum Out of Pocket Limit** can be met by a combination of family members with no single individual within the family contributing more than the individual **network provider Maximum Out of Pocket Limit** amount in a Calendar Year.

Out-of-Network Provider Maximum Out of Pocket Limit

Individual

Once the amount of eligible **out-of-network provider** expenses you or your covered dependents have paid during the Calendar Year meets the individual **Maximum Out of Pocket Limit**, this Plan will pay 100% of such **covered expenses** that apply toward the limit for the remainder of the Calendar Year for that person.

Family Maximum Out of Pocket Limit

When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **out-of-network provider Maximum Out of Pocket Limit**, these expenses will also count toward a family **out-of-network provider Maximum Out of Pocket Limit**.

To satisfy this family **out-of-network provider Maximum Out of Pocket Limit** for the rest of the Calendar Year, the following must happen:

The family **Maximum Out of Pocket Limit** is a cumulative **Maximum Out of Pocket Limit** for all family members. The family **out-of-network provider Maximum Out of Pocket Limit** can be met by a combination of family members with no single individual within the family contributing more than the individual **out-of-network provider Maximum Out of Pocket Limit** amount in a Calendar Year.

The **Maximum Out of Pocket Limit** applies to both network and out-of-network benefits. **Covered expenses** applied to the out-of-network **Maximum Out of Pocket Limit** will be applied to satisfy the in-network **Maximum Out of Pocket Limit** and **covered expenses** applied to the in-network **Maximum Out of Pocket Limit** will be applied to satisfy the out-of-network **Maximum Out of Pocket Limit**.

Covered expenses that are subject to the **Maximum Out of Pocket Limit** include **prescription drug** expenses provided under the Medical or **Prescription drug** Plans, as applicable.

Expenses That Do Not Apply to Your Out-of-Pocket Limit

Certain covered expenses do not apply toward your plan **out-of-pocket** limit. These include:

- Charges over the **recognized charge**;
- Non-covered expenses;
- Expenses for non-emergency use of the emergency room;
- Expenses incurred for non-urgent use of an **urgent care provider**; and
- Expenses that are not paid, or **precertification** benefit reductions because a required **precertification** for the service(s) or supply was not obtained from Us.

Precertification Benefit Reduction *(GR-96782 S-09-30 02 V/A)*

The Booklet-Certificate contains a complete description of the **precertification** program. Refer to the “Understanding Precertification” section for a list of services and supplies that require **precertification**.

Failure to precertify your **covered expenses** when required will result in a benefits reduction as follows:

- A \$400 benefit reduction will be applied separately to each type of expense.

General *(GR-96782 S-28-01 01)*

This Schedule of Benefits replaces any similar Schedule of Benefits previously in effect under your plan of benefits. Requests for coverage other than that to which you are entitled in accordance with this Schedule of Benefits cannot be accepted. This Schedule is part of your Booklet-Certificate and should be kept with your Booklet-Certificate form GR-9N. Coverage is underwritten by Us.