WELCOME TO THE HEALTH PLAN

Thank you for choosing The Health Plan of West Virginia, Inc. (hereafter referred to as The Health Plan or Plan). The Health Plan is offering a Point of Service Plan which is designed to meet your health care needs by arranging for medical and hospital services for you through Network (contracted) physicians, hospitals, and other health care providers.

Our Network provider directory is available online at The Health Plan website, healthplan.org, or by contacting our Customer Service Department for assistance.

This Evidence of Coverage (Member Handbook) is designed to help you understand our services. Read it carefully to better understand your coverage. Refer to the "Schedule of Benefits" for any out-of-pocket expenses. If requested, The Health Plan will provide you with a member handbook at no charge.

The Health Plan is not an insurance company and does not agree to assume responsibility for all of the health care costs you may incur. We do agree to arrange to provide all of the health care services that are included as covered benefits under the "Schedule of Benefits." By following the procedures outlined, you will help us to provide you with appropriate, cost effective health care. Should you have any questions after reviewing this Handbook, please call us. We will be happy to assist you. Remember, this is your plan for good health.

If you need written information provided by The Health Plan in an alternate language or format due to special needs such as vision or reading impairments or language translation difficulties, please contact our Customer Service Department for assistance. Please see below.

Each subscriber or enrollee, by acceptance of the benefits described in this Evidence of Coverage shall be deemed to have consented to the examination of his or her medical records for purposes of utilization review, quality assurance, and peer review by The Health Plan or our designee.

WARNING: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND HOSPITALS. IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL THE RULES VERY CAREFULLY; INCLUDING THE COORDINATION OF BENEFITS SECTION, AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY.

Insurance Fraud Warning: "Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statements is guilty of insurance fraud."

Any questions or problems, please call or write us at: Customer Service Department, The Health Plan, 1110 Main Street, Wheeling, WV 26003; 888.847.7902; TDD 711. You can also contact us via our website: healthplan.org. The Nurse on Call is available 24 hours a day/7 days a week: 800.624.6961.

Office hours are Monday - Friday, 8:00 a.m.-5:00 p.m. Eastern Standard Time.

Table of Contents

1. WHAT IS A POINT OF SERVICE PLAN?

A Point of Service Plan provides you with benefits whether you receive medical care from a provider in The Health Plan Network or from an Out-of-Network provider. A Point of Service plan requires that members elect a Primary Care Physician (PCP).

2. HOW A POINT OF SERVICE PLAN WORKS.

When you receive covered services from Network providers, you will receive the higher level of benefits.

If you choose to receive covered services from an Out-of-Network provider, you will receive the lower level of benefits. You will also be responsible for any amount by which the Out-of-Network provider's billed charges exceed the Usual, Customary and Reasonable (UCR) payment level used by The Health Plan to reimburse Out-of-Network providers.

Benefits are subject to a benefit year deductible. The member must pay the deductible before benefits are payable by The Health Plan. Exempt from the deductible and any member cost-sharing, are services and prescriptions covered under Network "Preventive Care Services". In addition, any amount by which an Out-of-Network provider's billed charges exceed the UCR payment level will not be counted towards your Out-of-Network deductible or Out-of-Pocket maximum.

Please refer to the "Schedule of Benefits" to determine your out-of-pocket expenses.

3. OBTAINING SERVICES.

Network providers are the key to providing and coordinating your health care services. Benefits may be obtained from any appropriate provider; however, benefits are paid at the higher benefit level when received by Network providers.

Network providers can be found by visiting our website at healthplan.org or contacting our Customer Service Department for assistance. The status of providers listed in a directory may change. Please check the status of the provider before receiving services by either calling the provider's office or our Customer Service Department. If requested, we will provide you with a Provider Directory at no charge.

PRIMARY CARE PHYSICIAN (PCP). As members, you and your dependents have chosen a PCP from the list of physicians under contract with The Health Plan. These PCPs have agreed to provide or arrange for covered services for you and your dependents. For children, a pediatrician may be chosen as the PCP.

Role of the Primary Care Physician. It is important to establish a relationship with your PCP. Your PCP refers you to specialists, consults with other physicians when necessary and coordinates the medical care you receive.

If your PCP is new to you, make an appointment and get to know the doctor and staff. Having a doctor that knows you and that you are comfortable with allows you to make the most effective use of your health care benefits.

You have the right to designate any PCP who participates in The Health Plan Network and who is available to accept you or your family members. For information on how to select a PCP and for a list of PCP's contact our Customer Service Department or visit our website at healthplan.org.

Make your doctor appointments in advance. If you are unable to keep an appointment, please call the office as soon as possible. Claims associated with missed appointments are not covered by The Health Plan.

You may change your PCP once per calendar month. You must notify us before you see your new doctor either by calling our Customer Service Department or emailing info@healthplan.org.

Your PCP can be reached 24 hours a day, seven days a week by calling his/her office number. Leave a message with the answering service for the doctor to return your call. When your call is returned, explain the problem clearly. Your PCP will advise you on what to do.

If another doctor is covering for your PCP, you do not need The Health Plan's authorization before seeing that doctor.

OBSTETRIC GYNECOLOGY (OB/GYN) CARE. For OB/GYN care, a female member may see her PCP or a Network OB/GYN. Referrals are not required when seeking care from a Network OB/GYN. However, the OB/GYN may be required to comply with certain procedures such as obtaining prior authorization for certain services, following a pre-approved treatment plan, or requesting referrals.

SECONDARY CARE PHYSICIAN (SCP) CARE. Certain members may have the need to choose a Secondary Care Physician (SCP). SCPs are Network physicians that provide specialty care to a member on a routine basis. You may see your SCP without a referral**.** However, the SCP may be required to comply with certain procedures such as obtaining prior authorization for certain services, following a pre-approved treatment plan, or requesting referrals.

REFERRAL TO A SPECIALIST. Your PCP is your first contact for your health care needs. You may need a referral for any specialty care services after the initial specialist consultation. Your PCP or the specialist will notify The Health Plan of any necessary referrals for specialty care services.

If you have a condition that requires continuing specialty care, you may request a "standing referral" to a Network specialist from your PCP. Your PCP will consult with your specialist regarding a treatment plan. Once this has been approved, you will receive a "Referral Confirmation." The specialist will send regular consultation reports to keep your PCP advised of your progress. If further services are needed beyond the initial referral, your PCP must request a new referral from The Health Plan.

If you have a life-threatening, degenerative, or disabling condition that requires the services of a Network specialist over a long period of time, you should discuss this with your PCP. If your PCP and the specialist agree that your condition requires the coordination of a specialist, your PCP will contact us. Together, you, your PCP, the specialist, and The Health Plan will agree on a treatment plan. Once this is approved, the specialist will be authorized to act as your PCP in coordinating your medical care.

Newly enrolled members of The Health Plan who are seeing a specialist must contact their PCP immediately, as a new referral may be necessary.

All Non-Emergent Referrals Must Be Authorized In Advance. Referrals will not be approved after the fact.

IF YOU NEED BEHAVIORAL HEALTH SERVICES. To obtain Behavioral Health Services, you may contact a Plan behavioral health provider or call us for assistance 740.695.3585 or 1.877.221.9295. Substance Abuse services do not require referrals to be authorized in advance.

RESTRICTIONS ON CHOICE OF PROVIDERS. The Health Plan will not discriminate coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable law based on the health care provider's participation with The Health Plan or other coverage. However, providers must act within the scope of their agreement with The Health Plan.

ENTERING THE HOSPITAL. Your PCP or participating plan specialist will make the arrangements when you need hospital care. Show your identification (ID) card from The Health Plan when you are admitted.

An emergency admission to a Non-Network hospital must be called in to us within 48 hours (or as soon as reasonably possible). If and when your medical condition allows, your PCP and The Health Plan may arrange for you to be transferred to a Network hospital.

IF A PROVIDER LEAVES THE HEALTH PLAN. If your PCP or any plan hospital can no longer provide medical services because their agreement with The Health Plan ends, we will notify you in writing within 30 days.

We will cover all eligible services they provide between the date of termination and five business days from the date on the postmark.

Continuity of Treatment. If your provider's agreement with The Health Plan terminates and you are undergoing a course of treatment, we will continue to pay for covered services rendered by that provider until the course of treatment is completed or until we arrange for the reasonable and medically appropriate transfer of the treatment to another Network provider. In most cases, coverage will be authorized for no more than 90 days. If this situation occurs, you should contact our Customer Service Department.

PROVIDER REIMBURSEMENT/FILING A CLAIM. You are responsible for any office visit copay or coinsurance payment at the time you receive services. Always show your ID card from The Health Plan to all providers. If you receive services from a Non-Network provider, you may be required to pay for these services and send an itemized bill and receipt to us for reimbursement. Reimbursement is subject to the terms of your health benefit plan.

NON-COVERED SERVICES. If you receive services that are not covered under your health benefit plan, you are responsible for full payment to the provider of those services.

IF YOU RECEIVE A BILL. With the exception of a deductible, copays or coinsurance payments or non-covered services, Network providers may not bill you for covered services. If you receive a bill or statement, it is usually just a routine monthly summary of the activity on your account. If you have any questions about any amount(s) shown on the bill or statement, please contact our Customer Service Department.

NEW TECHNOLOGY ASSESSMENT. The Health Plan investigates all requests for coverage of new technology using the Hayes Medical Technology Directory® and current evidenced-based medical/scientific publications. If further information is needed, we utilize additional sources including Medicare and Medicaid policies and Food and Drug Administration (FDA) releases. This information is evaluated by our Medical Director(s) and other physician advisors.

PRIVACY AND CONFIDENTIALITY. Federal and State laws protect the privacy of your medical records and personal health information. The Health Plan protects your personal health information as required by these laws.

Your personal health information includes the personal information you gave to The Health Plan when you enrolled in our plan as well as your medical records and other medical and health information.

The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. The Health Plan's Notice of Privacy Practices tells you about these rights and explains how we protect the privacy of your personal health information. This notice can be found by visiting our website or contacting our Customer Service Department for a copy.

How do we protect the privacy of your health information?

- We make sure that unauthorized people do not see or change your records.
- In most situations, if we give your personal health information to anyone who is not providing your care or paying for your care, we are required to get written permission from you first. Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are required or otherwise permitted by law.
    - For example, we are required to release health information to governmental agencies that are checking on quality of care.

You can see the information in your records and know how it has been shared with others.

- You have the right to look at your medical records held at The Health Plan and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will consider your request and decide whether the changes should be made.
- You have the right to know how your personal health information has been shared with others for any purposes that are not routine.
- If you have questions or concerns about the privacy of your personal health information, please call The Health Plan Customer Service Department.

STATEMENT OF ERISA RIGHTS. As a member with The Health Plan, you may be entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

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 Ave., 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.

PHYSICIAN AND OTHER PROVIDERS ARE INDEPENDENT CONTRACTORS. All physicians and providers providing health care services for The Health Plan members are independent contractors with The Health Plan. They are not employees or agents of The Health Plan.

4. OUT-OF-NETWORK PROVIDERS.

You may receive covered services from any physician or other provider who is not in The Health Plan Network. When an Out-of-Network provider furnishes care, your benefits will be provided under the Out-of-Network provisions of this agreement.

Please talk with a Customer Service Representative prior to obtaining any non-emergent or urgent care Out-of-Network to determine if the covered service requires preauthorization. Failure to do so may subject you (the member) to a penalty of up to $500. This penalty will not apply to your annual out of pocket maximum.

The benefits provided for Out-of-Network services will be equal to the UCR charge for the covered service minus any applicable deductible, coinsurance payment or copayment listed in the "Schedule of Benefits." You will be responsible for the coinsurance payment or copayment and any amount by which the billed charges exceed the UCR payment.

Out-of-Network providers may ask you to pay them directly or to submit their charges to The Health Plan. See "Claims Payment" for more information.

5. NETWORK HOSPITALS.

You may receive covered services from any Network hospital or other provider under contract with The Health Plan Network listed on your I.D. card. Additional Network information can be found on The Health Plan website

Before an elective admission to a Network hospital, it is you and/or your PCP's responsibility to obtain pre-certification directly from The Health Plan. Please contact The Health Plan Customer Service Department. You, or your physician, must be prepared to provide The Health Plan with appropriate medical information in order for The Health Plan to determine that the proposed hospitalization is medically necessary and appropriate and otherwise meets the criteria for authorization.

You or your physician must obtain pre- certification for your hospitalization from The Health Plan at least seven days prior to the start of your Network inpatient hospital stay. If you (the member) fail to obtain pre-certification for a Network hospitalization, a penalty of up to $500 per admission may apply. This penalty will not apply to your annual Out-of-Pocket maximum.

6. OUT-OF-NETWORK HOSPITALS.

If you choose to receive covered services from a hospital that is not in The Health Plan Network, your stay will be covered at the lower level of benefits.

Before an elective admission to an Out-of-Network hospital, it is **your** responsibility to obtain pre-admission certification directly from The Health Plan. Please contact our Customer Service Department. You, or your physician, must be prepared to provide The Health Plan with appropriate medical information in order for The Health Plan to determine that the proposed hospitalization is medically necessary and appropriate and otherwise meets the criteria for authorization.

You or your physician must obtain pre-admission certification for your hospitalization from The Health Plan at least seven days prior to the start of your Out-of-Network inpatient hospital stay. If you (the member) fail to obtain pre-admission certification for an Out-of-Network hospitalization, a penalty of up to $500 per admission may apply. This penalty will not apply to your annual Out-of-Pocket maximum.

The Out-of-Network benefits provided will be equal to the UCR charge for the covered service minus any applicable deductible, coinsurance payment or copayment listed in the "Schedule of Benefits." You will be responsible for the coinsurance payment or copayment and any amount by which the billed charges exceed the UCR payment.

NOTES: Tertiary providers are not considered In-Network with The Health Plan. Covered services received from Tertiary providers that are not preauthorized by The Health Plan will be covered as Out-of-Network. For a complete listing of tertiary providers, please visit healthplan.org or contact our Customer Service Department.

In order to receive the higher level of benefits, you should seek medical care from Network providers.

In order to receive benefits, your medical care must be deemed medically necessary and appropriate by The Health Plan and listed as a covered service in the "Schedule of Benefits."

Any emergency admission must be called in to The Health Plan within 48 hours or as soon as reasonably possible.

7. HEALTH CARE / UTILIZATION MANAGEMENT.

The Health Plan has a Utilization Review process in place that is designed to review medical necessity and appropriateness of health care services. These services include pre-service, concurrent and retrospective review to determine when services should be covered by The Health Plan. Their purpose is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place of service that they are performed. The Health Plan requires that covered services be medically necessary and appropriate for benefits to be provided. When setting or place of service is a part of the review, services that can be safely provided to you in a lower cost setting will not be medically necessary if they are performed in a higher cost setting.

PRIOR AUTHORIZATION. Network Providers are required to obtain prior authorization in order for you to receive benefits for certain services. Health Care/Utilization Management decisions are based on multiple sources including medical policy, clinical guidelines, pharmacy and therapeutic guidelines. The Health Plan may determine that a service that was initially prescribed or requested is not medically necessary if you have not previously tried an alternative treatment that is more cost effective.

The Health Plan's Health Care/Utilization Management decisions are not intended to restrict or deny care and services. The Health Plan monitors under-utilization of important services such as preventive services, medications, and care for chronic conditions (such as asthma and diabetes).

Our Health Care/Utilization Management Review staff is available 24 hours a day, seven days a week and can be contacted by calling 800.624.6961 to answer any questions, or you can visit The Health Plan's website healthplan.org.

REQUEST TYPES

Precertification. A required review of services, treatment or admission for a benefit coverage determination which must be obtained prior to the service, treatment or admission start date. For emergency admission, you or your authorized representative or Physician must notify The Health Plan within 24 hours of the admission or as soon as possible within a reasonable amount of time.

Predetermination. An optional voluntary Prospective or Concurrent request for a benefit coverage determination for a service or treatment. The Health Plan will review your Evidence of Coverage (member handbook) to determine if there is an exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will determine whether the service meets the definition of medically necessary and under the Evidence of Coverage or is experimental/investigational as that term is defined in the Evidence of Coverage.

Retrospective Medical Review. A retrospective review for a benefit coverage determination to determine the medical necessity and appropriateness of experimental/investigational nature of a service, treatment, or admission that did not require pre-certification and/or did not have a predetermination review preformed. Medical reviews occur for a service, treatment or admission in which The Health Plan has a related clinical coverage guideline. These are typically initiated by The Health Plan.

Most Network providers know which services require precertification and will obtain any required pre-authorization or request a predetermination if they feel it is necessary. Your PCP and other network providers have been provided detailed information regarding Health Care/Utilization Management procedures. They are responsible for assuring that the requirements of Health Care/Utilization Management are met. The ordering provider, facility or attending physician will contact The Health Plan to request a pre-authorization or predetermination review. We will work with the requesting provider for the precertification request. You may designate an authorized representative to act on your behalf for a specific request. The representative can be anyone who is 18 years of age or older.

WHO IS RESPONSIBLE FOR PRECERTIFICATION?		
Services provided by a Network provider	**Services provided by a Tertiary Care provider**	**Services provided by an Out-of-Network provider**
Provider	Provider	***Member*** is responsible

The Health Plan will apply our clinical coverage guidelines; such as medical policy, internally developed clinical guidelines, and preventive care clinical coverage guidelines to assist in making our medical necessity and appropriateness decision. These guidelines reflect the standards of practice and medical interventions identified as appropriate medical practice. The Health Plan Evidence of Coverage (member handbook) and Group Contract take precedence over these guidelines.

You are entitled to receive, upon request and free of charge, reasonable access to any documents related to your request. To request this information, please contact our Customer Service Department at 888.847.7902.

The Health Plan may waive, enhance, modify or discontinue certain medical management processes including utilization management, case management, and disease management. If in our discretion, such changes is in furtherance of the provision of cost effective, valued based and/or quality service.

REQUEST CATEGORIES

Non-urgent request. A request for medical care or services for which application of the time periods for making a decision does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

Urgent. A request for precertification or predetermination for urgent care services meaning medical care or other service for a condition where application of the timeframe for making non-urgent or non-life threatening care determinations is either of the following:

1. Could seriously jeopardize the life, health or ability to regain maximum function, or risk the safety of the member or others due to the members' psychological state.
2. In the opinion of the provider with knowledge of the members medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request or would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.
3. The seriousness of the members' condition requires an expedited review.

Concurrent. A request for pre-authorization or predetermination that is conducted during the course of treatment or admission. If a Concurrent Review request is not approved, the member may proceed with and Expedited External Review while simultaneously pursuing and Expedited Internal Appeal Process.

Prospective (pre-service). A request for pre-certification or predetermination that is conducted prior to the service, treatment or admission.

Retrospective (post service). A request for pre-certification or predetermination that is conducted after the service, treatment or admission has occurred. Retrospective Review does not include a documentation, accuracy of coding or adjudication of payment. The Health Plan permits a member to have a Retrospective Review for a service that required prior authorization but that prior authorization was not obtained if the service meets all of the following:

1. The service is directly related to another service for which prior approval has already been obtained and that has already been performed.
2. The new service was not known to be needed at the time the original prior authorized service was performed.
3. The need for the new service was revealed at the time the original authorized service was performed.

Once the written request and all necessary information is received The Health Plan shall review the claim for coverage and medical necessity and appropriateness. The Health Plan shall not deny a claim for such a new service based solely on the fact that a prior authorization approval was not received for the new service in question.

ELECTRONIC PRECERTIFICATION. A request that is sent to The Health Plan by a Health Care Practitioner via secure electronic communication. Electronic receipt of the request is sent to the health care practitioner acknowledging that the request was received. If the prior authorization request is lacking information, The Health Plan shall indicate to the health care practitioner within 2 business days the specific additional information that is required to process the request. The health care practitioner shall provide the additional information requested within 3 business days from the time the request is received or the prior authorization is deemed denied and a new request must be submitted. This only applies to

health care practitioners. For a listing of services requiring prior authorizations, please visit myplan.healthplan.org.

RETROACTIVELY DENYING AUTHORIZATION. The Health Plan, after approving a proposed admission, treatment, or health care service by a participating provider based upon the complete and accurate submission of all necessary information relative to an eligible member shall not retroactively deny this authorization if the provider renders the health care service in good faith and pursuant to the authorization and all of the terms and conditions of the providers contract with The Health Plan.

APPROPRIATE RESPONSE. Approved or denied.

RECEIPT OF THE REQUEST. The Health Plan will provide an electronic receipt to the requestor that the prior authorization request was received. Faxes or proprietary payer portals not following the NCPDP SCRIPT standard are not considered secure.

INCOMPLETE REQUESTS. The provider will be notified of the specific information needed to process the request.

Provider responsibility. The provider shall provide an electronic receipt to The Health Plan acknowledging that the request for additional information was received.

DECISION AND NOTIFICATION REQUIREMENTS. Timeframes and requirements listed are based on State and Federal regulations. Where State regulations are stricter than Federal regulations, The Health Plan will abide by State regulations. You may contact The Health Plan Customer Service Department for more information.

The Health Plan will accept secure electronic prior authorization requests for prescriptions using NCPDP SCRIPT standard ePA transactions and for prior medical benefit authorization requests through a secure electronic transmission, using standards established by the Council for Affordable Quality Healthcare on operating rules. The Health Plan will provide an electronic receipt to the requestor that the prior authorization request was received. Faxes or proprietary payer portals not following the NCPDEP SCRIPT standard are not considered secure.

Claim determinations are divided into the following categories:

1. **Urgent (pre-service)**. Decision/notification as soon as possible, but no later than 48 hours after receipt of the request. Oral notification of the decision to the member (whether adverse or not) as soon as possible, but no later than 48 hours after receipt of the request. Written or electronic notifications, to the member or member's representative, no later than 3 days after the oral notification.
2. **Non-urgent (pre-service)**. Decisions/notifications for Non-Urgent Pre-Service from your attending physician, treating practitioner, or health care facility by secure electronic communication shall be completed within a reasonable period of time appropriate to the medical circumstances; but not later than 7 days after the receipt of the request.

   Decision/notification not received through electronic communication shall be completed within two business days after obtaining all necessary information; but not later than 15 calendar days after the receipt of the request. The Health Plan shall notify the requestor by telephone or facsimile within three business days after making the initial certification.

   In case of adverse determination, The Health Plan shall notify the provider or health care facility rendering the health care service, by telephone, within three business days after making the adverse determination. Then shall provide written or electronic confirmation, of the telephone notification, to the member and the provider or health care facility within one business day after making the telephone notification.

3. **Urgent concurrent**. Decisions for concurrent care treatment extensions shall be made as soon as possible, taking into account the medical exigencies, but no later than 24 hours after the receipt of the request; provided that any such claim is made to The Health Plan at least 24 hours prior to the expiration of the prescribed period of time or number of visits.

4. **Concurrent**. In the case of certifying an extended stay or additional healthcare services that are not requested within the 24 hour window (non-urgent concurrent). Decision as soon as possible, no later than 48 hours of receipt of the request. The Health Plan shall notify the provider or health care facility rendering the health care service by telephone or facsimile within one business day after making the certification. The determination shall be made in advance, with sufficient time to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

5. **Post service decision**. Decision shall be made within a reasonable time frame, but no later than 30 days after receipt of the request.

   An extension may be taken one time for up to 15 days; provided that The Health Plan determines that such an extension is necessary, due to matters beyond their control, and notifies the member, prior to the expiration of the initial 30 day period of the circumstances requiring the extension of time and the date by which The Health Plan expects to render a decision. If the extension is necessary due to failure of the member to submit the information necessary to make a decision, then the notice of extension shall specifically describe the information required. The member shall be provided at least 45 days from the receipt of the notice; within, which to provide the specified information.

   The Health Plan shall provide notice of the decision to the member and practitioner in writing, within 5 business days after making the decision. The notification of an adverse determination shall reference the specific plan provisions or guidelines on which the determination was based.

ADVERSE BENEFIT DETERMINATIONS. The Health Plan notification will include the principal reason(s) for the decision; including specific utilization review criteria or benefit provision used in making the determination. We will also include instructions for requesting a written statement of the clinical rationale used to make the decision. We will provide a written statement of the clinical rationale to any authorized person making the request and following the instructions. The notification will also explain the instructions for initiating an appeal of the decision, including a description of the review procedures and the time limits for the same.

See "What to Do When You Have a Question, Suggestion, Complain, Or Appeal" for more information.

OBTAINING NECESSARY INFORMATION. If additional clinical is needed to make our decision, The Health Plan will notify the requesting provider and/or send notification to you, or your authorized representative, of the specific information necessary to complete the review**.** If you or a provider will not release the necessary information needed to make a decision, The Health Plan may deny approval. Necessary information includes; but is not limited to, the results of any face-to-face clinical evaluation or second opinion that might be required. If we do not receive the specific information requested or if the information is not complete by the timeframe identified in the notification, a decision will be made based on the information that is available.

We will provide notification of our decision in accordance with state and federal regulations. Notification may be given in the following methods:

- **Verbal**. Oral notification given to the requesting provider via telephone or electronic means if agreed by the Provider.
- **Written**. Mailed referral notification or electronic means including fax given to, at a minimum, the requesting provider and the member or authorized representative.

Pre-certification does not guarantee coverage for or payment of the service or procedure reviewed. For benefits to be paid on the date you receive service:

1. You must be eligible for benefits, premium must be paid for the time period that services are rendered;
2. The health care service, drug device is covered under the your health benefit plan;
3. You must not have exceeded any applicable limits; and
4. The service or procedure meets The Health Plan's standards for medical necessity and appropriateness and prior authorization.

CASE MANAGEMENT PROGRAM. In certain circumstances, especially in the case of a very serious illness or injury, The Health Plan may make available its Case Management Program services to the member. This is strictly a voluntary program; no member is obligated to participate and benefits will not be adversely affected.

The Case Management Program is administered by The Health Plan. Case managers are medical professionals who will work with your attending physician to identify alternate courses of treatment and the best way to use your benefit dollars. They can be of invaluable assistance in locating resources to assist in your recovery. This service is made available for members identified with Opioid Use Disorders.

If you are selected as a candidate for case management, you will be contacted by a case manager who will then work with you and your physician throughout the course of treatment. If you have any questions about the Case Management Program, please contact The Health Plan at 800.624.6961.

CHRONIC DISEASE MANAGEMENT. The Health Plan makes available, education and support for members with chronic respiratory and cardiac diseases, such as COPD, Congestive Heart Failure, and Type I and Type II Diabetes. Registered nurses are available to address questions or concerns related to your particular health issues. They will contact members with these chronic conditions by phone to provide education.

HIGH RISK PREGNANCY. The Health Plan provides education and support to women who have conditions that make pregnancy high risk for poor outcomes. This includes, but is not limited to, drug or alcohol abuse; diabetes and pregnancy; tobacco use; previous miscarriage or fetal anomaly; high blood pressure or other medical conditions that could impact the mother or fetus. Registered nurses are available by phone for questions or concerns and to assist the member with obtaining appropriate care and treatment to promote a positive pregnancy outcome.

8. ELIGIBILITY

The following persons (unless otherwise provided in the Group Medical and Hospital Service Agreement) are eligible for coverage and the subscriber (employee) must list them on the initial enrollment form. The only other time that you may enroll a dependent is during your employer's open enrollment period or when there is a special enrollment period due to a qualifying event.

SUBSCRIBER. (Must reside within the Service Area) The employee who meets eligibility requirements established by the employer and in accordance with the Group Medical and Hospital Service Agreement.

SPOUSE. (Must reside within the Service Area) The legal spouse of the subscriber. Common-law and divorced spouses are not eligible for coverage.

DIVORCE. You must notify your employer to remove your ex-spouse and any other ineligible dependents from your coverage at the time of the annulment, dissolution, or when the divorce decree is final.

DEPENDENT CHILDREN. (Unmarried or married) of either the subscriber or subscriber's spouse are eligible until their 26th birthday, regardless of where they live. This includes a dependent child attending an out-of-area college or post high school trade school or if there is a QMCSO. Dependent children must use a participating provider, coverage for services rendered outside the service area by Non-Network providers is limited to emergency medical conditions.

The Health Plan will not deny enrollment of a dependent child on the basis that any of the following applies:

- The child was born out of wedlock.
- The child does not reside in your household or within the Service Area.
- The child is not claimed as a dependent on the Federal tax return of the parent.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO). A QMCSO is any court judgment, decree, or order that provides for child support related to health benefits. These children are not required to live within the Service Area but are required to choose a Plan PCP and receive all non-emergency/urgent health care services in the Service Area. Court ordered children are permitted to enroll without regard to any enrollment period restrictions. Legal documents are required (e.g., copy of court judgment). Coverage for services rendered outside the Service Area by Non-Network providers is limited to emergency medical conditions.

DEPENDENT CHILDREN WITH DISABILITIES. The Health Plan will continue coverage for a dependent child who is incapable of self-sustaining employment by reason of physical handicap or intellectual disability. These dependents must be primarily dependent upon the subscriber for support and maintenance.

The child must have been incapacitated before reaching the limiting age and has been continuously incapacitated since then. The Health Plan must receive satisfactory proof of such incapacity and dependency within 31 days of the child's reaching the limiting age. After this, proof may be required once every two years.

You must notify The Health Plan if the dependent's marital or tax exemption status changes and they are no longer eligible for continued coverage. Failure to provide this information could result in termination of the child's coverage.

NATURAL CHILDREN. If the subscriber or spouse is not married to the natural mother/father, legal documents are required to prove the parental relationship.

ADOPTED CHILDREN. A child will be considered adopted from the earlier of:

- Placement in your home.
- The date of an entry of an order granting custody of the child to you. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption.

Legal documentation is required.

STEPCHILDREN. Legal documents are required (e.g., birth certificate or divorce papers) to establish the parental relationship.

LEGAL GUARDIANSHIP OR CUSTODY OF CHILDREN. Both natural parents must be physically or mentally handicapped to the point where they cannot take care of the child. Legal documents are required.

DEPENDENTS OF DEPENDENTS. Not eligible.

MARRIAGE, NEWBORN, OR OTHER NEWLY ACQUIRED DEPENDENTS. The subscriber must submit a new enrollment form through his/her employer within 31 days of the event.

Coverage for Person in Custody or Confined in Jail. The Health Plan may limit or exclude coverage for the reason that a member is under confinement or is otherwise under the custody of law enforcement, and a government entity is wholly or primarily responsible for rendering or arranging for health care services for the member. Excluded is coverage for health care services rendered to a member if the injury or sickness for which the services were rendered resulted from an action or omission for which the governmental entity operating the correctional facility, or the governmental entity with which the law enforcement officer is affiliated is liable.

DEATH OF A SUBSCRIBER. Dependents may be eligible for continuation coverage under the employer group's health benefit plan. See your benefits office for details.

GROUP ANNUAL OPEN ENROLLMENT PERIOD. During the group's annual open enrollment period, an eligible employee may elect to enroll in the group's health plan, as a single or with dependents, as well as add, modify, or terminate coverage under the group health plan. Any changes elected during the open enrollment period will be effective as of the first day of the Benefit Period following the close of the open enrollment period.

SPECIAL ENROLLMENT PERIOD. A time outside the Annual Open Enrollment Period when you can enroll in group health insurance. You may qualify for a Special Enrollment Period if you've had a loss of eligibility for coverage or a qualifying life event. Examples include: legal separation/separate maintenance; moving out of the enrollment area; divorce; death of the employee; "aging out"; termination; reduction in hours of employment; involuntary exhaustion of COBRA; getting married; having a baby; adoption; or placement for adoption of a child. If you do not enroll within 31 days of the event, you must wait until your employer's next annual open enrollment period to apply.

Newly acquired dependents must be added to your coverage within 31 days of the event. You must notify your employer and submit an application and any requested legal documentation to add a newly acquired dependent. If we receive the enrollment materials within 31 days of the event, the effective date of the dependent's coverage will be:

- The date of birth or placement for adoption.
- Marriage will be in accordance with Master Group Contract, please see your employer's benefit office.

Court ordered children are permitted to enroll without regard to enrollment period restrictions. See your employer's benefits office for details.

Loss of eligibility for other coverage requires that you notify your employer and submit an application and the Certificate of Creditable Coverage from the other health benefit plan within 31 days. Loss of coverage due to the individual's failure to pay premiums or termination of coverage for cause, such as fraud, do not qualify as a Special Enrollment. The Health Plan coverage will be effective first of the following month the receipt of the properly completed enrollment materials.

If you qualify for a Special Enrollment Period, you have 31 days following the date of event to enroll. If you miss that window, you must wait until your employer's next Annual Open Enrollment Period to apply.

Medicaid or CHIP - Eligible employees or dependents may also enroll if the following apply:

- The employee's or dependents Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility
- The employee or dependent becomes eligible for a subsidy (state premium assistance program) under Medicaid or CHIP.

The employee has 60 days following the qualifying event (loss of Medicaid/CHIP or of the eligibility determination) to request Special Enrollment. If you miss that window, you have to wait until the next Open Enrollment Period to apply. See your benefit office for details.

Effective Date of Coverage. Coverage for an eligible subscriber and/or their dependents will be effective:

- In accordance with the provisions of the Master Group Contract and this Certificate;
- Upon receipt by The Health Plan of a properly completed enrollment materials; and
- Only when premiums are paid.

If an eligible person is confined to an inpatient hospital on the effective date of coverage, the health services related to the confinement will be covered by The Health Plan. Services must be deemed medically necessary and appropriate by The Health Plan.

ADDING AND REMOVING DEPENDENTS. IT IS THE SUBSCRIBER'S RESPONSIBILITY TO NOTIFY THE EMPLOYER IMMEDIATELY AND NO LATER THAN 31 DAYS OF ANY CHANGES WHETHER ADDING OR REMOVING DEPENDENTS.

PLAN ADMINISTRATOR. Your employer is the Plan Administrator under the Service Agreement. He/she is solely responsible for administering the Service Agreement for the Group plan members. This includes applying the eligibility requirements and complying with any Federal, State, Local law or regulations. The Health Plan is the Administrator for claims determination only.

Final determination for all eligibility and coverage will be made by The Health Plan. We have the sole and absolute discretion to construe and interpret the provisions of the Service Agreement. The Health Plan may conduct eligibility audits and request eligibility verification from the member. Failure to supply the information may be cause for termination.

Note: Individuals electing to enroll/re-enroll with The Health Plan that have violated the "Termination of Coverage" section of this Agreement whereby the member is responsible for repayment for claims incurred and paid by The Health Plan after the member's previous termination, may not be permitted enrollment/re-enrollment in The Health Plan until such claims have been repaid to The Health Plan.

Verification of eligibility or benefits is not a guarantee that services are payable.

9. TERMINATION OF COVERAGE.

MEMBER. A member's coverage with The Health Plan may end for any of the following reasons:

- You fail to pay, or have paid for you, the required prepayments.
- You no longer meet the eligibility requirements.

GROUP. A Group's coverage with The Health Plan may end for the following reasons:

- Non-payment of premiums.
- If the Group fails to comply with material provisions of the Service Agreement.

BENEFITS AFTER CANCELLATION OF COVERAGE. If you are an inpatient on the date coverage ends, the benefits of this coverage will continue until the earliest of the following:

- The effective date of any new coverage.
- The date of discharge.
- The attending physician determines that inpatient care is no longer medically indicated.
- The maximum in benefits have been reached.

All benefits will cease at 11:59 p.m. Eastern Standard Time on the effective date of termination. After termination, neither The Health Plan nor Network providers have any further liability or responsibility under the Service Agreement.

The employee must immediately notify the employer if a covered dependent no longer meets the eligibility requirements. It is the responsibility of the employer to notify The Health Plan if any member fails to continue to meet the eligibility requirements within 31 days of the event. If The Health Plan provides benefits because of a failure to be notified, we may refuse to pay for these benefits. If benefits were paid, The Health Plan may recover the amount paid for services from the employee, employer, or dependent.

NON-DISCRIMINATION. No one who is eligible to enroll as a subscriber or dependent will be refused enrollment or terminated by The Health Plan based on health status, health care needs, genetic testing, disability, or age.

CERTIFICATE OF CREDITABLE COVERAGE. Once your coverage ends with The Health Plan, you may request The Health Plan send you a Certificate of Creditable Coverage indicating the length of time you were covered without a 63 day lapse in coverage.

10. RESCISSION OF COVERAGE.

A rescission of your coverage means that the coverage may be legally voided retroactively to the day The Health Plan began to provide you with coverage; just as if you never had coverage under The Health Plan.

Your coverage can only be rescinded if you (or a person seeking coverage on your behalf), performs an act, practice, or omission that constitutes fraud; or if you (or a person seeking coverage on your behalf) makes an intentional misrepresentation of material fact, as prohibited by the terms of your plan. Your coverage can also be rescinded due to such an act, practice, omission or intentional misrepresentation by your employer.

You will be provided with 30 calendar days' advance notice before your coverage is rescinded. You have the right to request an internal appeal of a rescission of your coverage. Once the internal appeal process is exhausted, you have the additional right to request an External Independent Review.

11. CONTINUATION OF COVERAGE.

IF THE HEALTH PLAN ENDS OPERATIONS. In the event The Health Plan would end operations, your benefits would be covered until the Service Agreement expires. All prepayments must be made in accordance with the terms of the Service Agreement. If you are receiving a course of treatment when The Health Plan ends operations, covered services will continue to be provided by network providers as needed to complete medically necessary services for the course of treatment. If you are receiving inpatient care at a hospital, coverage will be continued for up to 30 days after the end of operations. If The Health Plan ends operations, you may have to pay for health care services rendered by a Non-Network provider whether or not The Health Plan authorized the services.

For more information, call our Customer Service Department.

State Continuation Coverage . If your employment ends, you and your eligible dependents may be able to continue your group coverage, up to 18 months, through the employer under State law. To be eligible for State Continuation Coverage (Mini-COBRA), you must meet all the following guidelines:

- You must have been covered continuously under the group policy for three months prior to involuntary employment termination.
- Your termination is not the result of your gross misconduct; and
- You must not be or become eligible for Medicare coverage or any other group health benefit plan

See your benefits office for details.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA) CONTINUATION COVERAGE. If any of the following events occur and your employer group has 20 or more employees, you or your dependents may be able to continue your group coverage under the federal COBRA:

- Termination of your employment (for reasons other than gross misconduct) or reduction of hours of employment;
- Termination of your employment due to Chapter 11 Reorganization by your employer
- Your death;
- Your divorce or legal separation/separate maintenance;
- The loss of eligibility as a dependent child; or
- Your eligibility for Medicare benefits.

See your benefits office for details.

CONTINUATION OF COVERAGE DURING MILITARY SERVICE. Group coverage can be continued if a subscriber (employee) is called to active duty in any branch of the Armed Forces under the federal Uniformed Services Employment and Reemployment Rights Act (USERRA). The covered subscriber and dependents may continue group coverage for up to 24 months.

The continuation period begins on the date coverage would have terminated because the reservist was called to active duty.

Covered dependents may continue coverage for up to 36 months if any of the following events occurs during the 24 month period:

- The death of the reservist;
- The divorce or separation of a reservist from the reservist's spouse; or
- A covered dependent child's eligibility ends under this coverage.

The subscriber and/or dependent must complete and return to the employer any election form within 31 days of the date coverage would terminate. The subscriber and/or dependent must pay any required premium to the employer not to exceed 102% of the group rate.

Continuation coverage will end on the date any of the following occurs:

- The subscriber or dependent becomes covered by another group plan;
- The maximum period of months expires;
- The subscriber or dependent does not make the required payment;
- The subscriber is discharged from active duty and fails to apply for reemployment within the time period required. Failure to timely apply for reemployment following discharge from active duty will extinguish any rights to continuation coverage under USERRA. Such individuals may have continuation coverage rights under COBRA if it is within 18 months after the employee left employment; or
- The Service Agreement with The Health Plan is terminated.

See your benefits office for details.

CONTINUATION OF COVERAGE THROUGH THE HEALTH INSURANCE MARKETPLACE. If your group coverage ends, you and/or your dependents can shop for coverage through The Health Insurance Marketplace as provided under the Patient Protection and Affordable Care Act (PPACA). For more information and

guidance, visit www.healthcare.gov . You may qualify for premium savings based on your household income.

12. COORDINATION OF BENEFITS.

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one plan. Plan is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total allowable expense.

DEFINITIONS

A Plan is any of the following that provides benefits or other services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(1) Plan includes: group and non-group insurance contracts; health maintenance organization (HMO) contracts; closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

(2) Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; supplemental coverage as described by law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each other part is treated as a separate Plan.

This plan means, in a COB provision, the part of the contract providing the benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The ORDER OF BENEFIT DETERMINATION RULES determine whether the Plan is a primary plan or secondary plan when the person has coverage under more than one Plan. When this plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When this plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total allowable expense.

ALLOWABLE EXPENSE is a health care expense, including deductibles, copayments or coinsurance payments that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an allowable expense. In addition, any expense that a 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 that are not allowable expenses.

(1) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.

(2) If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similarly reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.

(3) If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.

(4) If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the allowable expense for all Plans.

However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the Secondary Plan to determine its benefits.

(5) The amount of any benefit reduction by the Primary plan because a covered person has failed to comply with The Plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

Closed panel plan is a Plan that provides 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 excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES. When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows.

A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

B. Except as provided in Paragraph (2),

(1) a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.

(2) Coverage that is obtained, by virtue of membership, in a group that is designed to supplement a part of a basic package of benefits and provides that this 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.

C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:

(1) Non-dependent or dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber, or retiree is the Primary plan. The Plan that covers the person as a dependent is the Secondary plan. 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, policyholder, subscriber, or retiree is the Secondary plan and the other Plan is the Primary plan.

(2) Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows.

a. For a dependent child whose parents are married or are living together, whether or not they have ever been married:

- The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or
- If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

However, if one spouse's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), we will follow the rules of that plan.

b. For a dependent child whose parents are divorced or separated or not living together; whether or not they have ever been married.

- If a court decree states that one of the parents is responsible for the dependent 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. This rule applies to plan years commencing after the Plan is given notice of the court decree;
- If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
- If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
- If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

1. The Plan covering the Custodial parent;
2. The Plan covering the spouse of the Custodial parent.
3. The Plan covering the non-custodial parent; and then
4. The Plan covering the spouse of the non-custodial parent.

c. For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active, retired, or laid-off employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D (1) can determine the order of benefits.

(4) COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by State or other Federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber, or retiree or covering the dependent of an employee, member, subscriber, or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled C (1) can determine the order of benefits.

(5) Longer or shorter length of coverage. The Plan that covered the person as an employee, member, policyholder, subscriber, or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.

(6) If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, this plan will not pay more than it would have paid had it been the Primary plan.

EFFECT ON THE BENEFITS OF THIS PLAN. When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans, during a plan year, are not more than the total allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total allowable expense for that claim. In addition, the Secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service be a non-panel provider, benefits are not payable by one closed panel plan, COB shall not apply between that Plan and other closed panel 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 payable under this plan and other Plans. The Health Plan may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other Plans covering the person claiming benefits. The Health Plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give The Health Plan any facts we need to apply those rules and determine benefits payable.

FACILITY OF PAYMENT. A payment made under another Plan may include an amount that should have been paid under this plan. If it does, The Health Plan may pay that amount to the organization that made a payment. That amount will then be treated as though it were a benefit paid under this plan.

The Health Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY. If the amount of the payments made by The Health Plan is more than The Health Plan should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it was paid or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

COORDINATION DISPUTES. If you believe that we have not paid a claim properly, you should first attempt to resolve the problem by contacting us, see "What to Do When You Have a Question, Suggestion, Complaint, Or Appeal" for more information. You may also call 888.847.7902; TDD 711or visit our website at healthplan.org for a description of the appeal procedures. If you are still not satisfied you may call the West Virginia Offices of the Insurance Commissioner for instructions on filing a consumer complaint.

Consumer Service Division

West Virginia Offices of the Insurance Commissioner

304.558.3386 or 1.888.879.9842

Website: http://wvinsurance.gov

MEDICARE AND EMPLOYER GROUP HEALTH PLANS (EGHP). If any enrolled member is entitled to Medicare benefits, Federal law will control whether The Health Plan or Medicare is primary. See your benefits office for details.

13. SUBROGATION AND REIMBURSEMENT.

The Health Plan may pay benefits on your behalf for treatment resulting from an injury or illness for which another person, plan, program, or insurance is legally responsible for payment. Examples include but are not limited to first party Workers' Compensation benefits as well as first or third party automobile, medical payments, personal injury protection, uninsured/underinsured motorists benefits, umbrella or excess insurance and/or other liability insurance of another person or entity, as well as self-insured entities.

If The Health Plan pays these benefit(s), we have the legal right to substitute ourselves for you for the limited purpose of making a claim to recover the benefits we paid on your behalf.

We have a legal right to recover benefits payments limited to medical expenses we paid on your behalf from you or another person, plan, program, or insurance that is legally responsible for paying for your treatment. The Health Plan may recover those paid benefits through reimbursement (if you receive payment from that responsible party), by assignment or by subrogation. You (or your legal representative) need to cooperate with The Health Plan (or a company that we have contracted with to recover subrogation claims) in the recovery process. If you do not, we have the legal right to recover our payments and costs (including attorneys' fees) by formal action against you for the reimbursement of money owed to us.

You (or your legal representative) must sign documents and do whatever is necessary for us to exercise our reimbursement, assignment, and subrogation rights. You (or your legal representative) must not do anything to limit, interfere with, or prejudice these rights.

The Health Plan's subrogation and reimbursement rights are a first priority lien on any recovery. The Health Plan is entitled to recover up to the full amount of benefits we have paid without regard to whether you (or your legal representative) have been made whole or received full compensation for

damages and without regard to any legal fees expended or costs that you (or your legal representative) has paid or are owed.

The Health Plan's right of recovery shall not be reduced due to the "Double Recovery Rule," "Made Whole Rule," "Common Fund Rule," or any other legal equitable doctrine. Our right of recovery takes preference over any other claims against the recovery. The Health Plan's subrogation rights are enforceable regardless of whether the settlement proceeds are designated as payment for medical expenses or otherwise, and the member must repay to The Health Plan the benefits paid on his or her behalf from another insurer of third party from any settlement proceeds.

14. CLAIMS PAYMENT.

NOTICE AND PROOF OF CLAIM - Written notice of claim (itemized copy of bill or industry standard claim form completed by the provider and any applicable receipts) must be submitted to The Health Plan within 90 days after services are incurred or as soon as reasonably possible. Submission must be no later than one year following the 90-day period allowed to file the claim, unless you are not legally competent to do so. When submitting a claim, be sure The Health Plan identification number and the member's name are listed on the claim. Please mail to the following address:

Customer Service Department
The Health Plan
1110 Main Street
Wheeling, WV 26003

TIME OF PAYMENT OF CLAIMS. The Health Plan will pay all benefits covered under this certificate within 30 days after we receive a complete and accurate written claim. If additional information is required to decide the claim, we will notify you within that period. If we deny payment for a claim, in whole or in part, we will give you our specific reasons for this denial and information about your appeal rights.

15. LIMITATIONS ON COVERAGE.

ACTS OF GOD. War, public disaster, emergency, general epidemic or other conditions not within the control of The Health Plan may prevent the furnishing of covered services under this certificate. We shall make a good faith effort to arrange for comparable services to the extent possible. However, The Health Plan and Network providers shall not be liable for any resulting delay.

SERVICE/PAYMENT. Unless otherwise required by law, The Health Plan has no obligation to furnish covered services if it has not received the required payments.

BENEFITS PERSONAL. Covered services provided under this certificate are personal and may not be assigned. Any attempted assignment shall render this Contract void.

NON-COVERED SERVICES. You are personally responsible for any financial obligation you or any of your dependents incur when you/they receive non-covered services.

16. WHAT TO DO WHEN YOU HAVE A QUESTION, SUGGESTION, COMPLAINT, OR APPEAL.

The Health Plans Customer Service Department will answer any questions regarding the following:

- Benefits;

- Deductibles and Out of Pocket Maximums;
- Copays and/or Coinsurance payment amounts;
- Referral processes;
- Provider directories or help with locating providers in the Service Area;
- Authorizations;
- Appeal procedures; and
- Complaints.

You can contact a customer service representative Monday through Friday, during regular business hours, by calling 888-847-7902; TDD 711; or email info@healthplan.org.

WHAT IS A COMPLAINT? A complaint is an expression of dissatisfaction that can often be resolved by an explanation from The Health Plan of our procedures and your benefits. A complaint can be expressed to The Health Plan orally at the time of the incident or through a subsequent phone call or letter.

Complaints/Concerns about Quality of Care. You may submit a written complaint relating to the quality of care or other concerns regarding services rendered by a health care provider. Send to:

Quality Improvement Department
The Health Plan
1110 Main Street
Wheeling, WV 26003

The complaint will be investigated and appropriate action taken.

WHAT IS AN APPEAL? An appeal is a request from you to The Health Plan to change a previous determination or to address a concern you have regarding confidentiality or privacy.

You have the right to appeal decisions of The Health Plan. If you feel we did not authorize, or provide, or that we limited the benefits you should receive under The Health Plan, or you have an administrative complaint, you may file an appeal. All Adverse Benefit Determination notifications contain explicit information on how to file an appeal.

The Health Plan has an "Appeals Coordinator" that can assist and guide members through the appeal process. The Health Plan wants to assure that all members, authorized persons, and providers have an important voice in The Health Plan through an effective Appeal Procedure. The Appeals Coordinator can be contacted Monday through Friday, during regular business hours, by calling: 888.847.7902; TDD 711. You may also write to or contact in person at:

Appeals Coordinator
The Health Plan
1110 Main Street
Wheeling, WV 26003

Fax: 740.699.6163
Email: info@healthplan.org

The Health Plan's focus is on developing and implementing products and services that manage and improve the health and well-being of our members.

Appeals and complaints will be handled according to State and/or Federal law.

The Appeal Procedure will involve a Health Plan employee with problem solving authority in each step of the Appeal Procedure. Medically related appeals will have physician involvement in the review process.

You are entitled to receive free of charge and upon request, reasonable access to or a copy of, all relevant documents reviewed to make the appeal decision. You may submit written comments, documents, or other information relevant to your appeal.

WHAT YOU CAN APPEAL? - You may appeal The Health Plan's adverse benefit determination, which is the decision by The Health Plan to deny, reduce, or terminate a requested health care service or payment in whole or in part, including all of the following:

- A determination that the health care service does not meet The Health Plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, including experimental or investigational treatments.
- A determination of an individual's eligibility for individual health insurance, including coverage offered to individuals through a non-employer group to participate in a health benefit plan.
- A determination that a health care service is not a covered benefit.
- The imposition of an exclusion, source of injury, network, or any other limitation on benefits that would otherwise be covered.
- Not to issue individual health insurance coverage to an applicant, including coverage offered to an individual through a non-employer group.
- A determination that a non-formulary prescription drug does not meet The Health Plan's requirements for medical necessity and appropriateness.
- To rescind coverage on a health benefit plan.

INTERNAL APPEALS. Should you receive a denial of services, you or an authorized person, may request an Internal Appeal. You have the right to designate an authorized representative (e.g., your physician) to file an appeal with The Health Plan on your behalf and they may represent you in any level of the process. In case of requests for upcoming or ongoing care review decisions, your provider or health care facility (providing the service) with your consent, may also request the reviews.

Appeals are reviewed by staff members that did not make the initial determination and who are not the subordinates of the initial reviewer. For clinical issues, The Health Plan will use a Physician/Provider who has the same license as the Provider who will perform or has performed the service. The physician will review your medical records and determine if the service is covered. If the clinical review determines that the service is covered The Health Plan will pay for the service, if the clinical review determines that the service is not covered The Health Plan may deny the services. If the decision does not change, we will contact you and explain the next step in the process.

The appeal may be written, oral, or in person and must be received by The Health Plan no later than 180 days from the adverse determination.

For review of denied care or services not yet performed (pre-service), The Health Plan must make a decision within 15 calendar days of the appeal request. For review of care or services already received (post-service), The Health Plan must make a decision within 30 calendar days of the appeal request.

Urgent or Expedited Appeal requests. If you are appealing a decision made for urgent or expedited service, we will schedule a hearing as quickly as possible as but no later than 48 hours after the request is received. The Health Plan will contact you 24 hours after we have received your appeal and will make a decision as soon as possible, taking into account the medical exigencies of the case, but not later than 48 hours after we receive your request for an appeal.

If there is insufficient information for The Health Plan to make a decision, we will notify the requestor and the requestor will have at least 48 hours to provide the specified information. Once received, the decision must be made within 48 hours of receipt or expiration of time provided to the requestor to supply information, whichever is earlier.

NOTIFICATIONS OF APPEAL OUTCOME. Should The Health Plan deny your appeal you will be provided in writing the following:

- The specific reason(s) for the determination;
- Reference to the specific coverage provision on which the determination was based (e.g.,, reference to the specific section in your member handbook);
- Notice of an internal rule, guideline or protocol was utilized in making the determination, and if so, notice that a copy of such rule, guideline, or protocol is available upon request and free of charge;
- If the appeal decision is based on medical necessity, experimental or investigational treatment or a similar exclusion, the specific clinical rationale for the determination; and
- Notice of any further appeal rights.

REQUEST FOR EXTERNAL REVIEW. You may request an External Review of any adverse determination or final adverse determination made by The Health Plan. If your appeal is in response to an adverse benefit determination and the appeal decision that was based on a coverage exclusion because the service was not considered medical necessary or constituted experimental services, and the decision involves a denial, reduction, modification or termination of payment for health care services you have four months from either 1) the date we exceeded the time periods set forth above without reaching a decision; or 2) receiving an unfavorable decision from us to make a written request for External Review. The request for an External Review shall be made to the West Virginia Offices of the Insurance Commissioner (OIC). The request should be made to:

Consumer Service Division
West Virginia Offices of the Insurance Commissioner
P.O. Box 50540
Charleston, WV 25305-0540

Website: http://wvinsurance.gov

The OIC will forward a copy of the request to The Health Plan within two business days of the request. Within five business days, The Health Plan will send you and the OIC a determination of whether the request is complete and/or eligible for an Independent Review. If The Health Plan concludes that the request is not complete and/or ineligible for External Review, The Health Plan will notify you and the OIC of that conclusion and a statement of why the request is incomplete or ineligible. You may appeal an adverse decision to the OIC.

If the determination is made that The Health Plan's decision is subject to an External Review, the OIC shall forward the request to an Independent Review Organization (IRO) within two business days. The IRO shall have 45 days to provide a written determination upholding or reversing The Health Plan's decision, including the basis for the IRO's conclusion.

Generally, you must exhaust all of The Health Plan's internal remedies before seeking an External Review. However, you may request an Expedited External Review of an adverse decision or a final adverse decision of The Health Plan from the OIC immediately upon receipt of the same.

The OIC will immediately forward the request to The Health Plan, which shall immediately determine if the request is entitled to Expedited Review. By way of appeal or otherwise, the OIC may determine that the expedited request is eligible for review. If either or both the OIC or The Health Plan (if review by the

OIC is sought) determine that a request is not entitled to expedited consideration, you will be requested to exhaust The Health Plan's Internal Review process. If a request for expedited review is eligible, the OIC shall forward the request to an IRO within one business day. The IRO shall have no more than 72 hours to provide a written determination upholding or reversing The Health Plan's decision, including the basis for the IRO's conclusion. If either or both the OIC or The Health Plan (if review by the OIC is sought) determine that a request is not entitled to expedited consideration, you will be required to exhaust The Health Plan's Internal Review process.

The final External Review (Expedited External Review) decision is binding unless there are other remedies available under State or Federal law. You also have the right to appeal the Independent Review Organizations' (IRO's) decision in a court of competent jurisdiction.

Filing an Appeal to the West Virginia Offices of the Insurance Commissioner (OIC). If your appeal is regarding an adverse benefit determination that was not considered medically necessary or constituted experimental services, and the decision involves a denial, reduction, modification or termination of payment for health care services, after exhausting our Internal Review procedures and/or the External Review procedures described above, you may file an appeal with the OIC.

Consumer Service Division
West Virginia Offices of the Insurance Commissioner
P.O. Box 50540
Charleston, WV 25305-0540

Website: http://wvinsurance.gov

IF YOU HAVE QUESTIONS ABOUT YOUR RIGHTS OR NEED ASSISTANCE. At any time during our Internal Review process, you may also contact The Health Plan:

Appeals Coordinator
The Health Plan
1110 Main Street
Wheeling, WV 26003

Phone: 888.847.7902, TDD: 711
Fax: 740.699.6163
Email: info@healthplan.org

17. NEW TECHNOLOGY.

The Health Plan strives to keep pace with change and ensure members have access to safe and effective care. We continually review new trends in medical technology, procedures, pharmacological treatments and drugs. Scientific evidence, medical effectiveness and determinations from regulatory bodies are all components of the review of new technology. The Health Plan reviews this information to form the basis for coverage decisions in the future.

18. BENEFIT OR RULE CHANGES.

Benefit or rule changes must comply with State and/or Federal law minimum standards.

19. COVERED SERVICES/ITEMS.

Please see the "Schedule of Benefits" for any applicable deductible, copayment or coinsurance payment, and benefit limitations information.

This section describes the covered services available under your health benefit plan. These services are covered when they meet The Health Plan's guidelines, are provided or coordinated by a Network provider (except for emergency) and deemed medically necessary and appropriate by The Health Plan.

AMBULANCE/EMERGENCY TRANSPORTATION SERVICES

1. General Services

Ambulance Services are covered when a medical condition is such that the use of another type of transportation would endanger the patient's health.

Ambulance trips must be made to the closest local facility that can give covered services that are appropriate for your condition. If none of these facilities are in your local area, you are covered for trips to the closest facility outside your local area.

The ambulance must comply with state or local laws governing the licensing and certification of an emergency medical transportation vehicle.

Any ambulance usage specifically for your convenience or a family member or provider's convenience, is not covered.

General Ambulance Services are covered only when determined to be medically necessary and appropriate:

- From your home, scene of accident or medical emergency to a hospital.
- Between hospitals.
- Between hospital and Skilled Nursing Facility. (Requires Pre-authorization)
- From a hospital or Skilled Nursing Facility to your home. (Requires Pre-authorization)

Treatment of a sickness or injury by emergency medical professionals from an ambulance service when you are not transported will be covered if medically necessary and appropriate.

Other vehicles which do not meet the definition of Ambulance/Emergency Transportation Services are not covered services.

Ambulance services are covered as medically necessary:

- When ordered by an employer, school, fire, or public safety official and you are not in a position to refuse.
- When you are required by The Health Plan to move from a Non-Network provider to a Network provider.

Non-covered services for ambulance include, but are not limited to:

- A physician's office or clinic.
- A morgue or funeral home.
- A request to be closer to family.

2. Air Ambulance Services

Air ambulance is covered for emergent transportation only. The aircraft must meet air ambulance requirements, and the service is determined to be medically necessary and appropriate. Air ambulance for emergency transport is covered to the nearest hospital equipped to treat your condition only when transport by ground ambulance or other means would endanger your life; or

cause permanent damage to your health. Your symptoms at the time of transport must meet these requirements and must be verifiable or supported by the medical records of the provider or health care facility who treats you and by the ambulance company.

Air ambulance will not be covered if you are taken to a Hospital that is not an acute care Hospital (such as a skilled nursing facility or a rehabilitation facility), or if you are taken to a physician's office or your home.

AUTISM SPECTRUM DISORDER

Covered services include, services to children up to 21 with a medical diagnosis of Autism Spectrum Disorder which at a minimum shall include:

- Outpatient services including: speech and language and/or occupational therapy performed by a licensed therapist.
- Clinical therapeutic intervention defined as therapies supported by empirical evidence; which include but are not limited to Applied Behavior Analysis (ABA), provided by or under the supervision of a professional who is licensed, certified or registered by an appropriate agency of the State to perform the services in accordance with a treatment plan.
- Mental/Behavioral Health Outpatient Services performed by a licensed psychologist, psychiatrist or physician to provide consultation, assessment, development, and oversight of treatment plans.

This coverage is contingent upon treatments being medically necessary and ordered or prescribed by a licensed physician or licensed psychologist and in accordance with a treatment plan developed from a comprehensive evaluation by a certified behavior analyst for an individual diagnosed with autism spectrum disorder.

Progress reports are required on a semi-annual basis.

BEHAVIORAL HEALTH SERVICES

Coverage for inpatient services, outpatient services, and physician office and home visits for the treatment of behavioral health and substance use conditions are provided in compliance with the state law.

Covered services include, but are not limited to:

Inpatient services - Treatments, medications, individual or group psychotherapy, psychological testing, family counseling with family members to assist in your diagnosis and treatment, convulsive therapy including electroshock treatment or convulsive therapy.

Psychiatric Residential Treatment for Individuals under Age 21: A psychiatric residential treatment facility (PRTF) is a **non-hospital facility** offering intensive inpatient services to people who have various mental health issues and are under the age of 21. All services are supervised by a physician

Residential Treatment for Substance Use Disorders: Short term (usually 30 days or less) residential treatment for Substance Use Disorders: treatments, medications, individual and group therapy, family therapy and/or interventions to assist in your recovery from a substance use disorder.

Partial hospitalization. An intensive structured setting providing three or more hours of treatment or programming per day or evening. In a program that is available five days a week. The intensity of services is similar to inpatient settings. Skilled nursing care and daily psychiatric care are available if treatment is provided by a multidisciplinary team of behavior health professionals.

Intensive outpatient treatment or day treatment. A structured array of treatment services offered by practice groups or facilities. Intensive outpatient structured setting providing three hours of treatment per day, and the program is available at least two to three days per week. Intensive outpatient treatment may offer group, individual, and family services.

Outpatient treatment, or individual or group treatment. Office-based services, for example diagnostic evaluation, counseling, psychotherapy, family therapy, and medication evaluation. The service may be provided by a licensed mental health professional and is coordinated with the psychiatrist or other health care provider.

Non-covered services include, but are not limited to**:**

- Non-medical services or care provided or billed by a school, halfway house, custodial care center for the developmentally disabled.
- Services related to marital counseling/therapy.
- Group home placement for adults with psychiatric illness or substance use disorders.
- Wilderness camps.

Health Library Education

Members looking for educational resources have access to The Health Plan's health library. Information regarding substance use disorder and opioid addiction education can be found on the health library at healthplan.org. In addition to substance use disorder, other topics located within the health library include diabetes, mental health, pregnancy, congestive heart failure and autism.

CHRONIC PAIN REHABILITATION

Benefits are for non-cancer, non-end of life pain lasting more than three months or longer than the duration of normal tissue healing.

Covered services include:

- Chiropractic Services.
- Occupational Therapy.
- Osteopathic Manipulation.
- Pain Management Program.
- Physical Therapy.

Limited to 20 visits per event**.** An event in this setting is defined as an injury or illness, or surgical or outpatient procedure.

Note: If different types of therapy services are performed, then each different type of Therapy Service performed will be considered a separate therapy visit. Each therapy visit will count against the applicable maximum visits listed above.

CLINICAL TRIALS

Benefits are available for services for routine patient care rendered as part of a cancer trial if the services are otherwise covered services under this agreement and the clinical trial meets all of the following criteria:

- The purpose of the trial is to test whether the intervention potentially improves the trial participant's health outcome or the treatment is given with the intention of improving the trial participant's health, and is not designed simply to test toxicity or disease pathophysiology
- The trial does one of the following:
    a. Tests how to administer a health care service, item, or drug for the treatment of cancer.
    b. Tests responses to a health care service, item, or drug for the treatment of cancer.
    c. Compares the effectiveness of health care services, items, or drugs for the treatment of cancer.
    d. Studies new uses of health care services, items, or drugs for the treatment of cancer.
- The trial is approved by one of the following:
    a. The National Institute of Health or one of its cooperative groups or centers under the United States Department of Health and Human Services.
    b. The United States Food and Drug Administration.
    c. The United States Department of Defense.
    d. The United States Department of Veteran's Affairs.

Benefits do not include the following:

- A health care service, item, or drug that is the subject of the clinical trial.
- A health care service, item or drug provided solely to satisfy data collection and analysis needs for the cancer clinical trial that is not used in the direct clinical management of the patient.
- An investigational or experimental drug or device that has not been approved for market by the United States Food and Drug Administration.
- Transportation, lodging, food, or other expenses for the patient, or a family member or companion of the patient, that are associated with the travel to or from a facility providing the cancer clinical trial.
- An item or drug provided by the cancer clinical trial sponsors free of charge for any patient.
- A service, item, or drug that is eligible for reimbursement by a person other than The Health Plan, including the sponsor of the cancer clinical trial.

The Health Plan is prohibited by Federal law from doing any of the following:

- Denying a qualified member participation in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition.
- Denying or limiting, or imposing additional conditions on, the coverage of routine patient care for items or services furnished in connection with participation in the approved clinic trial.
- Discriminating against the member on the basis of his or her participation in the approved clinical trial.

For Clinical Trials other than Cancer Clinical Trials, a qualified member is generally a participant or beneficiary who is eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or another life-threatening disease or condition; and either (1) the referring health care professional is a participating provider and has concluded that the individuals participation in such trial would be appropriate or (2) the participant or beneficiary provides medical and scientific information establishing that the individuals participation in such trial would be appropriate.

The Affordable Care Act clinical trials provision defines "approved clinical trial" as a Phase I, Phase II, Phase III, or Phase IV trial that meets the definition of an approved clinical trial if it is:

1) A federally funded or approved trial.
2) Is either:
   I. Conducted under an investigational new drug application (IND) or investigational device exemption (IDE) reviewed by the Food and Drug Administration (FDA).
   II. A clinical trial that is exempt from the IND or IDE application requirements.

The Health Plan cannot deny coverage for routine care costs for clinical trials that meet the above conditions. Routine patient care generally includes all items and services consistent with the coverage provided under the plan (or coverage) that is typically covered for a qualified individual who is not enrolled in a clinical trial.

DENTAL SERVICES

Related to Accidental Injury - Outpatient Services, physician home and office services, emergency and urgent care services for dental work and oral surgery are covered if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth, or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the patient's condition. Injury as a result of chewing or biting is not considered an accidental injury. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examination and treatment to complete the repair. For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and final repair.

Covered services for accidental dental injury include, but are not limited to:

- Oral examinations.
- X-rays.
- Tests and laboratory examinations.
- Restorations.
- Prosthetic services.
- Oral surgery.
- Mandibular/maxillary reconstruction.
- Anesthesia.

Other Dental Services - The only other dental expenses that are covered services are facility charges for Outpatient Services. Benefits are payable for the removal of teeth or for other dental processes only if the patient's medical condition or the dental procedure requires a hospital setting to ensure the safety of the patient.

DIABETIC EQUIPMENT, EDUCATION, AND SUPPLIES

Diabetes self-management training for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when:

- Medically necessary;

- Ordered in writing by a physician or podiatrist; and
- Provided by physician, podiatrist, or a health care professional who has obtained certification in diabetes education by the American Diabetes Association.

Covered services also include physician prescribed medically necessary equipment and supplies used for the management and treatment of diabetes. See "Medical Supplies, Durable Medical Equipment (DME), and Appliances," "Preventive Care Services," "Physician Home Visits," and other services.

DIAGNOSTIC SERVICES

Diagnostic Services are tests or procedures performed when you have specific symptoms, to detect or monitor your condition. Coverage for Diagnostic Services, including when provided as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, Home Care Services, and Hospice Services, as medically appropriate, includes, but is not limited to:

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease.
- Magnetic Resonance Angiography (MRA).
- Magnetic Resonance Imaging (MRI).
- CAT scans.
- Laboratory and pathology services.
- Cardiographic, encephalographic, and radioisotope test.
- Nuclear cardiology imaging studies.
- Ultrasound services.
- Allergy tests.
- Electrocardiograms (EKG).
- Electromyograms (EMG) except that surface EMG's are not covered.
- Echocardiograms.
- Bone density studies.
- Positron emission tomography (PET scanning).
- Diagnostic tests as an evaluation to determine the need for covered transplant procedure.
- Echographies.
- Doppler studies.
- Brainstem evoked potentials (BAER).
- Somatosensory evoked potentials (SSEP)
- Visual evoked potentials (VEP).
- Nerve conduction studies.
- Muscle testing.
- Electrocorticograms (ECoG).
- Central supply (IV tubing) or pharmacy (dye) necessary to perform tests are covered as part of the test, whether performed in a hospital or physician's office.

EMERGENCY SERVICES

Emergency Services (including Emergency Room) - Emergency services are provided by a hospital emergency facility and includes emergency transportation. Emergency services are provided seven days a week, 24 hours a day whether you are in or out of the Service Area to evaluate, treat, and stabilize a medical condition and includes, when appropriate, provisions for transportation and indemnity payments or service agreements for out-of-area coverage. True emergency services are covered without regard to preauthorization whether you are in or out of the Service Area.

Services may be subject to a copayment or coinsurance payment. Emergency care rendered by a non-Network provider will be covered as a Network service, however the member may be responsible for the difference between the non-Network provider's charge and the Maximum Allowed Amount charges in addition to any applicable copayment, coinsurance payment, or deductible. A non-Network provider of emergency services may send you a bill for any charges remaining after The Health Plan has paid (this is called "balance billing").

The Maximum Allowed Amount for emergency care from a Non-Network provider will be the greatest of the following:

- The amount negotiated with Network providers for the emergency services furnished;
- The amount for the emergency service calculated using the same method The Health Plan generally uses to determine payments for Out-of-Network services but substituting the Network copayment or coinsurance payment and deductible for the Out-of-Network member cost; or
- The amount that would be paid under Medicare for the emergency service.

Emergency medical conditions include, but are not limited to, the following:

- Symptoms of a heart attack.
- Seizures or convulsions.
- Broken bones.
- Severe burns or lacerations.
- Unconsciousness.
- Poisoning.

When at all possible, emergency care should be provided by a facility within the service area.

What to do: When practical, call your PCP. He/she can direct you to the appropriate care and can assure proper follow-up to that care. When a phone call is not practical, go to the nearest emergency room (if possible) or call 911 for assistance. After treatment, contact your PCP within 48 hours or as soon as reasonably possible. By informing your PCP of the situation your care can be better coordinated.

Services will be subject to a copayment or coinsurance payment.

Follow-up care within the Service Area. Follow-up care must be coordinated by your PCP. Follow up care is not considered Emergency Care.

Follow-up care outside the Service Area. Only initial care for an emergency medical condition is covered. Any follow-up care outside the Service Area must be coordinated by your PCP and approved by The Health Plan. Follow up care is not considered Emergency Care.

An emergency admission to a Non-Network hospital must be called in to us within 48 hours (or as soon as reasonably possible). If and when your medical condition allows, your PCP and The Health Plan may arrange for you to be transferred to a Network hospital.

URGENT CARE SERVICES

Urgent care services means covered health care services that are provided for an unforeseen medical condition that would require medical attention without delay. This medical condition does not pose a threat to the life, limb, or permanent health of the injured or ill person. Urgent medical conditions include, but are not limited to, the following:

- Colds and cough, sore throat, flu;
- Earache;
- Persistent high fever;
- Minor cuts where bleeding is controlled;
- Sprains;
- Sunburn or minor burn; or
- Skin rash.

What to do:

1. **In the Service Area** - Call your PCP's office as soon as symptoms persist or worsen. In most cases, your PCP will be able to treat you the same day or the next day. If the office cannot schedule you within a reasonable time, you may seek treatment at a Plan urgent care facility.
2. **Outside the Service Area** - When practical, call your PCP's office for directions on what to do. Urgent medical conditions outside the Service Area may be treated by a physician's office or urgent care facility.

Services will be subject to a copayment or coinsurance payment depending on where you receive treatment.

ANY TIME AN URGENT CARE PHYSICIAN RECOMMENDS ADDITIONAL CARE, such as a return visit, seeing a specialist, additional testing or X-rays, etc., call our Customer Service Department **BEFORE** you receive the services. Customer Service can tell you if the service will be covered or if you need to contact your PCP.

Covered services received from a Network urgent care facility will be provided at the higher benefit level and Out-of-Network services at the lower benefit level. If you experience an accidental or a medical problem, the Plan will determine whether your injury or condition is an Urgent Care or Emergency Care situation for coverage purposes, based on your symptoms.

HABILITATIVE OUTPATIENT SERVICES

Health care services and devices that help a person keep, learn, or improve skills and functioning for daily living.

- Outpatient habilitation services including: speech and language, physical and/or occupational therapy performed by a licensed therapist.

HOME CARE SERVICES

Covered services are those performed in the home on a part time or intermittent basis by a Home Health Care Agency or other licensed health care provider. The member must be confined to the home for a

covered medical condition, and be physically unable to obtain needed medical services on an outpatient basis.

Covered services include, but are not limited to:

- Skilled nursing.
- Medical/social services.
- Diagnostic Services.
- Nutritional guidance.
- Home health aide services. The member must be receiving skilled nursing or therapy. Services must be furnished by appropriate trained personnel employed by the home health care provider. Other organization may provide services only when approved by The Health Plan, and their duties must be assigned and supervised by a professional nurse on staff of the home health care provider.
- Therapy Services (except for manipulation therapy which will not be covered when rendered in the home). Home care visit limits specified in the Schedule of Benefits for Home Care Services apply when therapy services are rendered in the home;
- Medical/surgical supplies.
- Durable medical equipment.
- Prescription drugs (only if provided and billed by a home health care agency)
- Private Duty Nursing.

Non-covered services include, but are not limited to:

- Food, housing, homemaker services, and home delivered meals.
- Home or outpatient hemodialysis services (these are covered under Therapy Services).
- Physician charges.
- Helpful environmental materials (hand rails, ramps, telephones, air conditioners, and similar services, appliances and devices).
- Services provided by registered nurses and other health care workers who are not acting as employees or under approved arrangements with a contract home health care provider.
- Services provided by a member of the patient's immediate family.
- Services provided by volunteer ambulance associations for which patient is not obligated to pay, visiting teachers, vocational guidance, and other counselor. Services related to outside, occupational, and social activities.

HOME INFUSION THERAPY

Benefits for Home Infusion Therapy include a combination of nursing, durable medical equipment, and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes, but is not limited to: injections (intra-muscular, subcutaneous, and continuous subcutaneous), antibiotic therapy, pain management, chemotherapy, Total Parenteral Nutrition (TPN), and Enteral nutritional therapy.

Lyme disease. Coverage is provided for long-term antibiotic therapy for a patient with Lyme disease when determined to be medically necessary and ordered by a licensed physician after making a thorough evaluation of the patient's symptoms, diagnostic test results, or response to treatment.

HOSPICE SERVICES

Hospice care may be provided in the home or at a hospice facility. The focus in hospice care is not to cure but to provide treatment for symptom and pain management for individuals with a life expectancy of six months or less. When approved by your physician.

Covered services include the following:

- Routine and continuous home care.
- Inpatient hospice and respite care.
- Skilled nursing services.
- Diagnostic Services.
- Physical, speech, and inhalation therapies if part of a treatment plan.
- Medical supplies, equipment, and appliances (benefits will not be covered for equipment when the member is in a facility that should provide such equipment).
- Prescription drugs given by the hospice.
- Home health aide.
- Counseling services.

Non-covered services include, but are not limited to volunteer and housekeeping services.

INPATIENT HOSPITAL, PHYSICIAN, AND SURGICAL SERVICES

Inpatient services include:

- Charges from a hospital or Skilled Nursing Facility or other covered provider for room, board, and general nursing services;
- Ancillary (related) services; and
- Professional services of a physician.

Room, Board, and General Nursing Services

- A room with two or more beds;
- A private room. The private room allowance is the hospital's average semi-private room rate unless it is medically necessary that you use a private room for isolation and no isolation facilities are available; and
- A room in a special care unit approved by The Health Plan. The unit must have facilities, equipment, and supportive services for intensive care of critically ill patients.

Ancillary (Related) Services

- Operating, delivery and treatment rooms and equipment;
- Prescribed drugs;
- Anesthesia, anesthesia supplies and services given by an employee of the hospital or other covered provider;
- Medical and surgical dressings, supplies, casts and splints;
- Diagnostic Services; and
- Therapy Services.

Professional Services

- **Medical care** visits limited to one visit per day by any one physician.
- **Intensive medical care** for constant attendance and treatment when your condition requires it for a prolonged time.
- **Concurrent care** for a medical condition by physician who is not your surgeon while you are in the hospital for surgery. Care by two or more physicians during a hospital stay when the nature or severity of your condition requires the skill of separate physicians.
- **Consultation** which is a personal bedside examination by another physician when requested by your physician. Staff consultations required by hospital rules; consultations requested by the patient; routine radiological or Cardiographic consultations; phone consultations; EKG transmittal via phone are excluded.
- **Surgery** and the administration of general anesthesia.
- **Newborn exam -** A physician other than the physician who performed the obstetrical delivery must do the examination.

Copay or Coinsurance Payment Waiver - When a member is transferred from one hospital or covered facility on the same day, any copay or coinsurance payment per admission in the Schedule of Benefits is waived for the second admission.

MATERNITY SERVICES

Maternity Services include inpatient and outpatient services, Physician Home Visits and Office Services as medically appropriate. These services are used for normal or complicated pregnancy, miscarriage, therapeutic abortion (abortion recommended by a provider), and ordinary routine nursery care for a healthy newborn.

Abortion means the ending of a pregnancy before the birth of the infant.

Miscarriage is a spontaneous abortion (occurs naturally and suddenly).

A therapeutic abortion is an abortion performed to save the life or health of the mother, or as a result of incest or rape.

Note: If a newborn child is required to stay as an inpatient past the mother's discharge date, the services for the newborn child will then be considered a separate admission from the maternity and an ordinary routine nursery admission, and will be subject to a separate inpatient coinsurance/copayment.

Coverage for the inpatient postpartum stay for the mother and newborn in a hospital will be, at a minimum, 48 hours for a vaginal delivery and 96 hours for a cesarean section. Coverage will be for the length of stay recommended by The American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their guidelines for prenatal care.

Follow-up care can be directed by either a physician or an advanced practice nurse after delivery. Services covered as follow-up care include physical assessment of the mother and newborn; parent education; assistance and training in breast or bottle feeding; assessment of the home support system; performance of any medically necessary and appropriate clinic tests; and any other services that are consistent with follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric, and nursing professionals. The coverage applies to services provided in a medical setting or through home health care visits. The coverage shall apply to a home health care visit only if the health care professional who conducts the visit is knowledgeable and experienced in maternity and newborn care.

Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if the attending physician or a certified nurse midwife determines that further inpatient postpartum care is not necessary for the mother or newborn child(ren) provided that the following are met and the mother or a person responsible for the mother a person responsible for the mother or newborn may include a parent, guardian, or any other person with authority to make medical decisions for the mother or newborn) concurs:

- In the opinion of the mothers attending physician or a certified nurse midwife, the newborn child meets the criteria for medical stability in the Guidelines for Perinatal Care prepared by The American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon evaluation of:
    1) The antepartum, intrapartum, and postpartum course of the mother and infant;
    2) The gestational stage, birth weight, and clinical condition of the infant;
    3) The demonstrated ability of the mother to care for the infant age discharge; and
    4) The availability of post discharge follow-up to verify the condition of the infant after discharge.

Covered services include at-home post-delivery care visits at the members residence by a Network Physician or Nurse performed no later than 72 hours following the mother and newborn's discharge include, but are not limited to:

- Physical assessment of the mother and newborn.
- Parent education.
- Assistance and training in breast or bottle feeding.
- Assessment of the home support system.
- Performance of any medically necessary and appropriate clinical tests.
- Any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric, and nursing professionals.

The coverage shall apply to services provided in a medial setting or through home health care visits. The coverage for a home health care visit shall only apply if the provider who conducts the visit is knowledgeable and experienced in maternity and newborn care.

MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT (DME), AND APPLIANCES

Medical supplies, equipment and appliances are covered as medically necessary under this benefit. If the supplies, equipment or appliances include comfort, luxury, or convenience items or features which exceed what is medically necessary in your situation or needed to treat your condition, reimbursement will be based on the maximum allowable amount for a standard item that is a covered service, serves the same purpose, and is medically necessary.

Any expense that exceeds the maximum allowable amount for the standard item which is a covered benefit is your responsibility. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates your condition.

Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below may be covered, as approved by The Health Plan. The repair, adjustment or replacement of the purchased equipment, supply or appliance is covered if:

- The equipment, supply, or appliance is a covered service.
- The continued use of the item is medically necessary.
- There is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).

In addition, replacement of purchased equipment, supplies, or appliance may be covered if:

- The equipment, supply, or appliance is worn or no longer functions.
- Repair is not possible or would equal or exceed the cost of replacement. An assessment by a rehabilitation equipment specialist or vendor should be done to estimate the cost of repair.
- Individual's needs have changed and the current equipment is no longer usable due to rapid growth, weight gain, or deterioration of function, etc.
- The equipment, supply, or appliance is damaged and cannot be repaired.

Benefits for repairs and replacement do not include the following:

- Repair and replacement due to misuse, malicious breakage, or gross neglect.
- Replacement of lost or stolen items.

The Health Plan may establish reasonable quantity limits for certain supplies, equipment, or appliance described below.

Covered services may include, but are not limited to:

Medical and surgical supplies - Certain supplies and equipment for the management of disease are covered under the prescription benefit. These supplies are considered a medical supply benefit if the supplies, equipment, or appliances are not received from a Network pharmacy to include prescription drugs and biologicals that cannot be self-administered and are provided in a physician's office.

Covered services may include, but are not limited to:

- Needles/Syringes.
- Oxygen.
- Surgical dressings.
- Splints and other similar items which serve a medical purpose.
- Allergy serum extracts.
- Chem strips, glucometer, lancets.
- Clinitest.
- Ostomy bags and supplies except charges such as those made by a pharmacy for purposes of a fitting are not covered services.
- Contraceptive devices including diaphragms, intra uterine devices (IUDs), and implants. Certain contraceptive devices are covered by The Health Plan at 100% as required by Federal law. For more information you may call our Customer Service Department or view the Federal government's web sites, http://www.healthcare.gov/center/regulations/prevention.html; or http://www.ahrq.gov/clinic/uspstfix.htm; http://www.cdc.gov/vaccines/recs/acip/.

Non-covered services include, but are not limited to:

- Adhesive tape.
- Cotton tipped applicators.

- Arch supports.
- Doughnut cushions.
- Hot packs, ice bags.
- Medijectors.
- Band-Aids.
- Thermometers.
- Petroleum Jelly.

Contact our Customer Service Department for any questions regarding whether a specific medical or surgical supply is covered.

Durable medical equipment - The rental (or at The Health Plan's option, the purchase) of durable medical equipment prescribed by a physician or other covered provider. Durable medical equipment is equipment which can withstand repeated use; e.g., could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; is not useful to a person in absence of illness or injury; and is appropriate for use in the patient's home. Examples include, but are not limited to: wheelchairs, crutches, hospital beds, and oxygen equipment. Rental cost must not be more than the purchase price. The Health Plan will not pay for rental for a longer period of time than it would cost to purchase equipment. Payment for related supplies is a covered service only when the equipment is a rental, and medically fitting supplies are included in the rental; or the equipment is owned by the member; medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is covered.

Covered services may include, but are not limited to:

- Hemodialysis equipment.
- Crutches and replacement of pads and tips.
- Pressure machines.
- Infusion pump for IV fluids and medicine.
- Glucometer.
- Cardiac, neonatal and sleep apnea monitors.
- Tracheotomy tube.
- Augmentive communication devices when approved by The Health Plan based on the member's condition.

Non-covered items may include, but are not limited to:

- Air conditioners.
- Ice bags/cold pack pump.
- Raised toilet seats.
- Rental of equipment if the facility is expected to provide such equipment.
- Trans lift chairs.
- Tub chair used in the shower.
- Treadmill exerciser.

Contact our Customer Service Department for any questions regarding whether a specific durable medical equipment is covered.

Prosthetics. Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes.

Covered services include purchase, filling, needed adjustment, repairs, and replacement of prosthetic devices and supplies that:

- Replace all or part of a missing body part and its adjoining tissues.
- Replace all or part of a function of a permanently useless or malfunctioning body part.

Prosthetic devices should be purchased and not rented, and must be medically necessary. Applicable taxes, shipping and handling are also covered.

Covered services include, but are not limited to:

- Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
- Left Ventricular Artificial Devices (LVAD).
- Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per contract year, as required by the Women's Health and Cancer Rights Act. Maximums for prosthetic devices, if any, do not apply.
- Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.
- Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are covered services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session.)
- Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or injury; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of surgery are not considered contact lenses, and are not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the member selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.
- Cochlear implant.
- Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
- Restoration prosthesis (composite facial prosthesis).
- Wigs (the first one following cancer treatment, not to exceed one per contract year).

Non-covered prosthetic appliances include, but are not limited to:

- Dentures, replacing teeth or structures directly supporting teeth.
- Dental appliances.
- Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets.
- Artificial heart implants.
- Wigs (except as described above following cancer treatment).
- Penile prosthesis in men suffering impotency resulting from disease or injury.

Contact our Customer Service Department for any questions regarding whether a specific prosthetic is covered.

Orthotic devices. Covered services are the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are included. The casting is covered when an orthotic appliance is billed with it, but not if billed separately.

Covered orthotic devices may include, but are not limited to, the following:

- Cervical collars.
- Ankle foot orthosis.
- Corsets (back and special surgical).
- Splints (extremity).
- Trusses and supports.
- Slings.
- Wristlets.
- Built-up shoe.
- Custom made shoe inserts.

Orthotic appliances may be replaced once per year per member when medically necessary in the member's situation. However, additional replacements will be allowed for members under age 18 due to rapid growth, or for any member when an appliance is damaged and cannot be repaired.

Non-covered services include, but are not limited to:

- Orthopedic shoes (except therapeutic shoes for diabetics).
- Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace.
- Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under medical supplies).
- Garter belts or similar devices.

Contact our Customer Service Department for any questions regarding whether a specific orthotic is covered.

OUTPATIENT SERVICES

Outpatient Services include facility, ancillary, facility use, and professional charges when given as an outpatient at a hospital, alternative care facility, clinic, or other provider as determined by The Health Plan. These facilities may include a non-hospital site providing diagnostic and therapy services, surgery, or rehabilitation, or other provider facility determined by The Health Plan. Professional charges only include services billed by a physician or other professional.

Covered services include, but are not limited to:

- Radiology.
- Laboratory.
- Imaging (e.g., CT/PET scans, MRA and MRI).

- Prescription Drugs and biologicals that cannot be self-administered including chemotherapy and generic specialty drugs.
- Radiation therapy.
- Renal dialysis.

PHYSICIAN HOME VISITS AND OFFICE SERVICES

Covered services include:

- **Office visits** for medical care and consultation to examine, diagnose, and treat an illness or injury performed in the physician's office.
- **Home visits** for medical care and consultations to examine, diagnose, and treat an illness or injury performed in your home.
- **Diagnostic services** for physical medicine therapies and other therapy services when given in the office of a physician or other professional provider.
- **Surgery and Surgical Services -** the surgical fee includes normal post-operative care (includes anesthesia and supplies).
- **Therapy Services** for physical medicine therapies and other therapy services when given in the office of a physician or other professional provider.
- **Other practitioner office visits** where the professional may be a nurse, physician assistant, chiropractor, podiatrist, psychologist, or other professional whose services require payment under State or Federal law.
- **Online clinic visit,** when available in your area, your coverage will include online clinic visit services. Covered services include a medical consultation using the internet via a webcam, chat or voice.

Non-covered services include, but are not limited to, communication used for:

- Reporting normal lab or other test result.
- Office appointment requests.
- Billing, insurance coverage, or payment questions.
- Requests for referrals to doctors outside the online care panel.
- Benefit precertification.
- Physician to physician consultation.

PREVENTIVE CARE SERVICES

Preventive Care Services include Outpatient Services and office services. Screenings and other services are covered as preventive care for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service.

Members who have current symptoms or have been diagnosed with a medical condition are not considered to require preventive care for that condition but instead benefits will be considered under the Diagnostic Services benefit.

Preventive Care Services in this section shall meet requirements as determined by Federal and State law. These services fall under the broad categories as shown below:

1. Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for:
    - Breast cancer.
    - Cervical cancer.
    - Colorectal cancer.
    - High blood pressure.
    - Type 2 diabetes mellitus.
    - Cholesterol.
    - Child and adult obesity.
2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
3. Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
4. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
    - Women's contraceptives, sterilization procedures and counseling. The four contraceptive method categories are covered under the "Preventive Care" benefit.

Contraceptive method	**Example of Contraception Product Type**
Barrier	Diaphragm, sponge, cervical cap and female condom
Hormonal	Oral contraceptive, injectable contraceptive, vaginal ring and patch
Emergency Contraceptives	Plan B, Ella (Rx only)
Implanted Device	IUD products

Covered products include all FDA approved 18 contraceptive methods available through the prescription drug benefit, including all OTC contraceptive barrier methods (diaphragm, female condom, spermicides, etc.), all hormonal methods (oral contraceptives, skin patch, injectable contraception and vaginal ring), and all contraceptive devices (Intrauterine systems and implants.) Emergency contraceptives (Plan B, Ella) are also covered through the prescription drug benefit.

Under the "Preventive Care" benefit, generic products and brand medications with no generic equivalent form, are covered. If member is unable to take the generic, a substitute (whether generic, formulary brand or non-formulary brand) will be provided at no cost to member.

The Health Plan's Pharmaceutical Management program has a process to allow members or his/her practitioner to make a medical necessity request to cover a service or FDA approved item within a specified method of contraception. The Health Plan will cover requested servic3e or FDA approved item at no cost based on determination of medical necessity. Medical necessity may include considerations such as severity of side effects, differences in permanence and reversibility of contraceptive and ability to adhere to the appropriate use of the term or service as determined by the prescribing provider. (See the "Non-Formulary Prescription Drug Exception" for more information on the exception request.) The Health Plan will defer to the determination of the attending provider regarding medical necessity.

- Breastfeeding support, supplies and counseling (one breast pump per benefit period).

- Gestational diabetes screening.

You may call our Customer Service Department for additional information about these services or view the federal government's web site, www.healthcare.gov/coverage/preventive-carebenefits

Covered services also include the following services required by State and Federal law:

- Routine screening mammograms - The total benefit for a screening mammography, regardless of the number of claims submitted by the providers. Women between 35 and 40 are covered 100% for the initial Network screening.
- Routine cytologic screening for the presence of cervical cancer and Chlamydia screening (including pap test).
- Child health supervision services from the moment of birth until age nine. Child health supervision services mean a periodic review of a child's physical and emotional status performed by a physician, by a health care professional under the supervision of a physician, or, in case of hearing screening, by an individual acting in accordance with WV law. Periodic review means a review performed in accordance with the recommendations of the American academy of pediatrics and includes a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations, and laboratory tests.

Other covered services are:

- Routine hearing screenings.
- Routine vision screenings.

SURGICAL SERVICES

Coverage for surgical services when provided as part of Physician Home Visits and Office Services, inpatient services, or Outpatient Services, as medically necessary and appropriate, includes, but is not limited to:

- Performance of accepted operative and other invasive procedures.
- The correction of fractures and dislocations.
- Anesthesia and surgical assistance when medically necessary.
- Usual and related pre-operative and post-operative care.
- Other medically appropriate procedures as approved by The Health Plan.

The surgical fee includes normal post-operative care.

Covered surgical services, as medically necessary include, but are not limited to:

- Operative and cutting procedures.
- Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy.
- Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.

RECONSTRUCTIVE/COSMETIC SERVICES

Benefits include reconstructive surgery to correct significant deformities caused by congenital or developmental abnormalities, illness, injury or an earlier treatment in order to create a more normal appearance. Benefits include surgery performed to restore symmetry after a mastectomy. Reconstructive services needs as a result of an earlier treatment are covered only if the first treatment would have been a covered service by The Health Plan.

Coverage for reconstructive services does not apply to orthognathic surgery. See "Surgical Services".

MASTECTOMY NOTICE

A member who is receiving benefits for a covered mastectomy or for follow-up care in connection with a covered mastectomy, on or after the date the Women's Health & Cancer Rights Act became effective for The Health Plan, and who elects breast reconstruction, will also receive coverage for:

- Reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

STERILIZATION

Sterilization for both females and males is a covered service. However, as prescribed by Federal law, certain sterilization procedures to include, but not limited to tubal ligations, are covered at 100% for female members. For additional information on sterilization, please contact our Customer Service Department.

TEMPOROMANDIBULAR OR CRANIOMANDIBULAR JOINT DISORDER AND CRANIOMANDIBULAR JAW DISORDER (TMD/CMD)

Medical benefits are provided for temporomandibular (joint connecting the lower jaw to the temporal bone at the side of the head) and craniomandibular (head and neck muscle) disorders. These are covered if provided within The Health Plan guidelines.

THERAPY SERVICES

When Therapy Services are given as part of Physician Home Visits and Office Services, inpatient services, Outpatient Services, or Home Care Services, coverage for these Therapy Services is limited to the following:

Physical Medicine Therapy Services - The expectation must exist that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time.

Physical therapy including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principals and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part**.**

Non-covered services include, but are not limited to:

- Maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness.
- Repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients).
- Range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities.
- General exercise programs.
- Diathermy, ultrasound, and heat treatments for pulmonary conditions.
- Diapulse.

- Work hardening.

Speech therapy for the correction of a speech impairment.

Occupational therapy for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts).

Non-covered services include, but are not limited to:

- Supplies (looms, ceramic tiles, leather, and utensils).
- Therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again.
- General exercises to promote overall fitness and flexibility.
- Therapy to improve motivation.
- Suction therapy for newborns (feeding machines).
- Soft tissue mobilization, myofascial.
- Adaptions to the home such as ramp ways, door widening, automobile adaptors, kitchen adaptation, and other types of similar equipment.

Manipulation therapy includes osteopathic/chiropractic manipulation therapy used for treating problems associated with bones, joints, and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy includes equal emphasis on the joints and surrounding muscles, tendons, and ligaments. Manipulations whether performed and billed as an office visit will be counted toward any maximum for manipulation therapy services as specified in the "Schedule of Benefits". Manipulation therapy services rendered in the home as part of home care services are not covered.

Other Therapy Services

Cardiac rehabilitation to restore and individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning, and maintenance are not covered.

Chemotherapy for the treatment of a disease by chemical or biological antineoplastic agents, including the cost of such agents.

Dialysis treatments of an acute or chronic kidney ailment which may include the supportive use of an artificial kidney machine.

Radiation therapy for the treatment of disease by X-ray, radium, or radioactive isotopes. Includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), as well as materials and supplies used in therapy and treatment planning.

Inhalation therapy for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation.

Covered services include, but are not limited to:

- Introduction of dry or moist gases into the lungs.
- Non-pressurized inhalation treatment.
- Intermittent positive pressure breathing treatment, air or oxygen, with or without nebulizer medication.

- Continuous positive airway pressure ventilation (CPAP).
- Continuous negative pressure ventilation (CNP).
- Chest percussion.
- Therapeutic use of medical gases or drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers.
- Broncho-pulmonary drainage and breathing exercises.

Pulmonary rehabilitation to restore an individual's functional status after an illness or injury.

Covered services include, but are not limited to:

- Outpatient short-term respiratory services for conditions which are expected to show significant improvement through short-term therapy.
- Inhalation therapy administered in a physician's office including, but are not limited to: breathing exercise, exercise not elsewhere classified, and other counseling.

Pulmonary rehabilitation in the acute inpatient rehabilitation setting is not a covered service.

PHYSICAL MEDICINE AND REHABILITATION SERVICES

A structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patient's ability to function as independently as possible; including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy, and services of a social worker or psychologist. The goal is to obtain practical improvement in a reasonable length of time in the appropriate inpatient setting.

Physical medicine and rehabilitation involves several types of therapy, not just physical therapy, and a coordinated team approach. The variety and intensity of treatments required is the major differentiation from an admission primarily for physical therapy.

Non-covered services for physical medicine and rehabilitation include, but are not limited to:

- Admission to a hospital mainly for physical therapy.
- Long term rehabilitation in an inpatient setting.

Day Rehabilitation Program services provided through a day hospital for physical medicine and rehabilitation are covered services. A Day Rehabilitation Program is for those patients who do not require inpatient care but still require rehabilitation therapy program four to eight hours a day, two or more days a week at a day hospital. Day Rehabilitation Program services may consist of physical therapy, occupational therapy, speech therapy, nursing services, and neuro psychological services. A minimum of two therapy services must be provided for this program to be covered service.

VISION SERVICES

Benefits are only available for medical and surgical treatment of injuries and/or diseases affecting the eye. Vision screenings required by Federal Law are covered under the "Preventive Care" benefit.

Benefits are not available for glasses and contact lenses except as described in the prosthetics benefits.

No additional ophthalmological services are covered, except as described above.

HUMAN ORGAN AND TISSUE TRANSPLANT SERVICES

Covered organ and tissue transplants include, but are not limited to:

- Liver.
- Bone marrow/stem cell.
- Heart/lung.
- Cornea
- Heart.
- Lung.
- Kidney.
- Pancreas.
- Bowel.
- Kidney/pancreas.

Covered Transplant Procedure. Any medically necessary human organ and stem cell/bone marrow transplants and transfusions as determined by The Health Plan including necessary acquisition procedures, harvest and storage, and including medically necessary preparatory myeloablative therapy.

Prior Approval and Preauthorization. The Health Plan strongly encourages you to call our Customer Service Department to discuss benefit coverage when it is determined a transplant may be needed. This must be done prior to having an evaluation and/or work-up for a transplant.

We will assist you by providing coverage information, including details regarding what is covered and whether any clinical coverage guidelines, medical policies, including preauthorization, Network provider requirements, or exclusions are applicable. Even if The Health Plan issues a prior approval for the covered transplant procedure, you or your provider must call our medical department for precertification prior to the transplant regardless if it is performed in an inpatient or outpatient setting.

Please note that there are instances where your provider requests approval for HLA testing, donor searches and/or a harvest and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing. The harvest and storage request will be reviewed for medical necessity and may be approved. However, such an approval for HLA testing, donor search and/or a harvest and storage is NOT an approval for the subsequent requested transplant. A separate medical necessity determination will be made for the transplant procedure.

Transportation and Lodging. The Health Plan will provide assistance with reasonable and necessary travel expenses as determined by us when you obtain prior approval and are required to travel more than 75 miles from your residence to reach the facility where your covered transplant procedure will be performed.

Our assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the member receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions. The member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to The Health Plan when claims are filed.

For lodging and ground transportation benefits, The Health Plan will provide the maximum benefit up to the current limits set forth in the Internal Revenue Code.

Non-covered services for transportation and lodging include, but are not limited to:

- Child care.
- Mileage within the medical transplant facility city.
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by us.
- Frequent flyer miles.
- Coupons, vouchers, or travel tickets.
- Prepayments or deposits.
- Services for a condition that is not directly related, or a direct result, of the transplant.
- Phone calls.
- Laundry.
- Postage.
- Entertainment.
- Interim visits to a medical care facility while waiting for the actual transplant procedure.
- Travel expenses for donor companion/caregiver.
- Return visits for the donor for a treatment of a condition found during the evaluation.

These benefits are only available when the covered person is the recipient of an organ transplant. No benefits are available when the covered person is a donor.

See "Schedule of Benefits" for more information, certain Transplant Services may be limited.

GENE THERAPY

Your plan includes benefits for cellular and gene therapy services, when The Health Plan approves the benefits in advance through precertification. To be eligible for coverage, cellular and gene therapy requests must meet The Health Plan's coverage criteria and be performed by an approved provider at an approved treatment center.

Genetic Therapy is not a covered for benefit for the following:

i. Services determined to be experimental/investigational
ii. Services provided by a non-approved provider or at a non-approved facility; or
iii. Services not approved in advance through precertification

PRESCRIPTION DRUG BENEFITS

Pharmacy Benefits Manager (PBM)

The pharmacy benefits available to you are managed by The Health Plan's Pharmacy Benefits Manager (PBM). The PBM is a pharmacy management company with which The Health Plan contracts to manage your pharmacy benefits. The PBM has a nationwide network of retail pharmacies, home delivery pharmacy, specialty pharmacy, and provides clinical management support services.

The management and other services the PBM provides include, among other, making recommendations to, and updating the covered prescription drug list referred as "The Formulary" and managing the pharmacy network.

The PBM, in consultation with our Pharmacy Department, also provides services to promote and enforce the appropriate use of pharmacy benefits, such as review for possible excessive use; recognized and recommended dosage regimens; drug interactions or drug/pregnancy concerns.

Off label use, as approved by The Health Plan or our PBM or when the drug has been recognized as safe and effective for treatment of that indication in one or more of the standard medical reference compendia adopted by the United States Department of Health and Human Services or in medical literature that meets certain criteria. Medical literature may be accepted only if all of the following apply:

- Two articles from major peer-reviewed professional medical journals have recognized the drug's safety and effectiveness for treatment of the indication for which it has been prescribed.
- No article from a major peer-reviewed professional medical journal has concluded that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which it has been prescribed.
- Each article meets the uniform requirements for manuscripts submitted to biomedical journal established by the international committee of medical journal editors or is published in a journal specified by the United States Department of Health and Human Services as acceptable peer reviewed medical literature.

You may request a copy of the formulary and Network pharmacies by calling The Health Plan's Pharmacy Department or visit our website at healthplan.org. The Formulary and Network pharmacies are subject to periodic reviews and may change from time to time. Inclusion of a drug or related item on the covered list is not a guarantee of coverage.

The Health Plan's Pharmaceutical Management Program has a process to allow members or practitioners to request, on the basis of medical necessity, coverage consideration for a non-formulary drug. These requests may be made by the member or physician. See the below section, "Non-Formulary Prescription Drug Exception" for more information.

Drugs Requiring Prior Authorization. Some drugs may require prior authorization**.** Prior authorization helps promote appropriate utilization and enforcement of guidelines.

At the time you fill a prescription, The Health Plan is informed of the prior authorization requirement through the pharmacy's computer system. The PBM uses pre-approved criteria, developed by the Pharmacy and Therapeutics Committee which is reviewed and adopted by The Health Plan. The Health Plan, or the PBM, may contact your provider if additional information is required to determine whether prior authorization should be granted. The decision will be communicated to both you and the prescribing provider. Policies and requirements for prior authorization can be found on the member and provider portals of healthplan.org.

The Health Plan will honor a previous authorization for an approved drug for a chronic condition for the twelve months or the last day of the covered person's eligibility under the plan. Chronic conditions means a medical condition that has persisted after reasonable efforts have been made to relieve or cure its cause has continued, either continuously or episodically, for longer than six months.

The twelve month approval is no longer valid and will automatically terminate if there are changes to Federal or State Laws or Federal regulatory guidance or compliance information prescribing that the drug in question is no longer approved or safe for the intended purpose. In addition, this twelve month limitation does not apply to the following:

- Medications that are prescribed for non-maintenance condition.
- Medications that have a typical treatment of less than one year.
- Medications that require an initial trial period to determine effectiveness and tolerability beyond which a year or greater, prior authorization period will be given.
- Medications where there is medical or scientific evidence that do not support a twelve month prior approval.

- Medication that are Schedule I or II controlled substance or any opioid analgesics or benzodiazepine.
- Medications that are not prescriber by a Network Provider as part of a care management program.

This section does not prohibit the substitution of any drug that has received a twelve month approval when there is a release of U.S. FDA approved comparable brand product or a generic counterpart of a brand product that his listed therapeutically equivalent by the FDA.

If prior authorization is denied, you have the right to appeal the decisions, see "What to Do When You Have a Questions, Suggestion, Complaint, Or Appeal." For a current list of drugs requiring prior authorization, please contact our Customer Service Department.

OPIOIDS. Opioid medications are used to manage moderate to severe pain due to a medical condition that is associated with pain syndromes. Prior authorization will be required for all extended release opiates for chronic pain. The clinic/provider must establish a pain management contract with the member before evaluation.

Members with a diagnosis of cancer or another condition associated with cancer or history of cancer will be able to obtain opiate medication without prior authorization. Members diagnosed with a terminal condition or enrolled in a hospice care program will also be able to receive opiate medications without the opioid prior authorization restrictions.

Seeking treatment for acute use of opiate agents. The acute use of opiate agents for moderate to severe pain will have limitations. This policy affects members who had an acute injury/medical treatment or surgical procedure.

Acute pain is defined by the Centers for Disease Control (CDC) as pain that is expected to last or have a normal tissue healing of less than 3 months. Pain exceeding these measurement is defined as chronic pain.

The first fill of an acute opiate will be limited to 5 days or 20 units. If opiate use is still required after first fill, medications will be limited to a maximum quantity or #120 in 30 days without a prior authorization. Use of more than one immediate release and one extended release opioid will require prior authorization from a physician.

See Healthcare/Utilization Management for information on prior authorizations.

If prior authorization is denied, you have the right to appeal the decision, see "What to do When you Have a Question, Suggestion, Complaint, or Appeal".

For a current list of drugs requiring prior authorization, please contact The Health Plan Pharmacy Department.

Drugs for the treatment of substance use disorder do not require prior authorization.

Therapeutic substitution of drugs is a program approved by The Health Plan and managed by the PBM. This is a voluntary program designed to inform members about possible alternatives to certain prescribed drugs. Only you and your physician can determine whether the therapeutic substitute is appropriate for you.

The therapeutic drug substitutes list is subject to periodic review and may change from time to time. Questions or issues regarding therapeutic drug substitutes, please contact our Pharmacy Department.

If a prescription is denied, you have the right to appeal the decision. See "What To Do When You Have A Question, Suggestion, Complaint, Or Appeal."

Step Therapy. Step therapy protocol means that a member may need to use one type of medication before another. The PBM monitors some prescriptions drugs to control utilization, to ensure that appropriate prescribing guidelines are followed, and to help members access high quality yet cost

effective prescriptions drugs. If a physician decides that the monitored medication is needed the prior authorization process is applied.

When coverage of a prescription drug is restricted for use under step therapy protocol, the member and physician have access to request a step therapy exception. The Health Plan will provide a prescription drug for treatment of the medical condition until step therapy exception determination is made.

A step therapy override determination request will be expeditiously granted if:

- The required prescription drug is contraindicated or will likely cause an adverse reaction or physical or mental harm to the member.
- The required prescription drug is expected to be ineffective based on the known relevant physical or mental characteristics of the member and the known characteristics of the prescription drug regimen.
- The member has tried the required prescription drug while a member of The Health Plan, or a previous benefit plan; or another prescription drug in the same pharmacologic class; or with the same mechanism of action and such prescription drug was discontinued due to a lack of efficacy or effectiveness, diminished effect or an adverse event.
- The required prescription drug is not in the best interest of the member, based upon medical appropriateness.
- The member is stable on a prescription drug selected by their physician for the medical condition under consideration.

Upon granting of a step therapy override determination, The Health Plan will authorize coverage for the prescription drug prescribed by the member's treating physician provided the prescription drug is covered prescription under the member's plan.

This section does not prevent:

- The Health Plan requiring a member to try and AB-Rated generic equivalent prior to providing coverage for the equivalent branded prescription drug.
- A Physician from prescribing a prescription drug that is determined to be medically appropriate.
- The Health Plan requesting documentation from the physician, or previous physician or carrier, to determine the necessity to support the override determination.

Specialty Drugs (sometimes referred to as "specialty pharmacy"). Specialty medications treat complex, chronic conditions and/or rare diseases. They may have specific handling, administration and/or monitoring requirements. Specialty medications may be injected, infused or taken by mouth. Specialty medications are often expensive treatments. Some specialty medications can only be dispensed by a few specialty pharmacies, these are known as limited distribution drugs.

For a complete list of specialty drugs, please contact The Health Plan Pharmacy Department or visit healthplan.org.

The Health Plan manages its own network of specialty pharmacies and reserves the right to redirect your specialty pharmacy benefit in the most cost effective manner as is clinically appropriated, included but not limited to, site of care (administration) and drug supply chain.

Legend Drugs. The Health Plan covers legend prescription drugs which are drugs that by Federal law, can be dispensed only pursuant to a prescription. These prescriptions are required to bear the legend "Caution: Federal law prohibits dispensing without a prescription."

Other covered prescription drug benefits include, but are not limited to:

- Generic Specialty Drugs;

- Injectable insulin and syringes used for administration of insulin and other injectables;
- Certain supplies and equipment; and
- Immunizations.

Cost sharing for prescription insulin drugs shall not exceed $100 for a 30-day supply of a covered prescription insulin, regardless of the quantity or type of prescription insulin prescribed. Insulin may be restricted to a formulary and require coverage criteria be satisfied.

Dispense as Written (DAW) Policy. If you or your provider request a brand name prescription when there is a generic equivalent available, you will be charged the difference in cost between the brand name and generic as well as pay the difference in copays. If your plan has a deductible, the difference in cost will not be used to satisfy your deductible.

Non Formulary Prescription Drug Exception. The Health Plan's Pharmaceutical Management Program has a process to allow members or his/her designee or practitioner to make an exception to cover a particular non-formulary drug. Exceptions may be received from The Health Plan via web, email, fax or phone.

- **Standard exception request**. The Health Plan must make its determination on a standard exception and notify the member or his/her designee or practitioner(s) no later than 72 hours following receipt of request containing information sufficient to complete the review. If the standard exception request is granted, The Health Plan must provide coverage of the non-formulary drug for the duration of the prescription, including refills.
- **Expedited exception request**. For exigent circumstances (which means a covered person either has a condition that may seriously jeopardize his or her life, health or ability to regain maximum function or is undergoing a current course of treatment using a non-formulary drug), The Health Plan must make its determination and notify the member or his/her designee or practitioner(s) no later than 24 hours following receipt of request containing information sufficient to complete the review. If the expedited exception is granted, The Health Plan must provide coverage of the non-formulary drug for the duration of the exigency.
- **External exception request**. If The Health Plan denies a request for a standard exception or for an expedited exception the member or his/her designee or practitioner(s) can request that the original exception request and subsequent denial of the request be reviewed by an independent review organization.

The Health Plan must make its determination on the external exception request and notify the member or his/her designee or practitioner(s) of its determination no later than 72 hours following its receipt of the request, if the original request was a standard exception request and no later than 24 hours following its receipt of the request, if the original request was an expedited exception request.

If The Health Plan grants an external exception review of a standard exception request, we must provide coverage of the non-formulary drug for the duration of the prescription, including refills. If The Health Plan grants an external exception review of an expedited exception request, we must provide coverage of the non-formulary drug for the duration of the exigency.

See WHAT TO DO WHEN YOU HAVE A QUESTION, SUGGESTION, COMPLAINT, OR APPEAL "External Independent Reviews" for more information.

Non-Covered Prescription Drug Benefits

Non-covered drug benefits include, but are not limited to:

- Prescription drugs dispensed by any home delivery service other than our PBM's.
- Drugs in quantities exceeding the quantity prescribed or for any refill dispensed later than one year after the date of the original prescription order.

- Drugs in quantities which exceed the limits established by The Health Plan, or which exceed any age limits established.
- Charges for the administration of any drug.
- Drugs consumed at the time and place where dispensed or where the prescription order is issued including, but not limited to, samples provided by a physician. This does not include any drugs used in conjunction with a Diagnostic Service or other drugs covered under medical supplies.
- Any drug which is being utilized for weight loss.
- Drugs not requiring a prescription by Federal law (including drugs requiring a prescription by State law, but not by Federal law), except for injectable insulin.
- Drugs for treatment of erectile dysfunctions or inadequacies, regardless of origin or cause.
- Devices used for impotence.
- Fertility drugs.
- Oral immunizations and biologicals, although they are federal legend drugs, are payable as medical supplies based on where the service is performed or the item is obtained. If such items are over the counter drugs, devices or products, they are not covered services.
- Early refills of lost or stolen medications.
- Coverage for experimental drugs not approved for any indication by the U.S. Food and Drug Administration.
- Over the counter drugs or devices unless required by Federal law as Preventive Care Services.
- Compound drugs unless there is at least one ingredient that requires a prescription.
- Certain legend drugs when any version or strength becomes available over the counter.
- Prescription drugs that are determined to be not Medically Necessary and/or Appropriate.

You have the right to request an exception.

See the above section regarding prescription drug exception process. Please contact our Pharmacy Department for more information.

How to Obtain Prescription Drug Benefits. As a member, you may obtain your prescription drugs at any Network pharmacy. For a location of a Network pharmacy, please call The Health Plan Pharmacy Department for assistance.

To fill your prescription(s), just present your identification (ID) card from The Health Plan to the pharmacy along with your prescription order. You will be required to pay a copayment or coinsurance payment at the time of service.

Home Delivery. Complete the Order and Patient Profile forms. You may mail written prescriptions from your physician, or your physician can phone or fax them to our PBM.

You will need to submit the applicable deductible and/or copayment or coinsurance payment to the PBM. For additional information on your prescription benefits, please contact The Health Plan Pharmacy Department at 800-624-6961 ext 7914; healthplan.org and/or our PBM at 800.988.2262 or visit their website at express-scripts.com.

20. DEFINITIONS.

ADVERSE BENEFIT DETERMINATION. A decision by a health plan issuer to deny, reduce, or terminate a requested health care service or payment in whole or in part including the following:

- A determination that the health care service does not meet the health plan issuer's requirements for medical necessity, appropriateness, health care setting, and level of care or effectiveness, including experimental or investigational treatments.
- A determination of an individual's eligibility for individual health insurance, including coverage offered to individuals through a non-employer group to participate in a plan or health insurance coverage.
- A determination that a health care service is not a covered benefit.
- The imposition of an exclusion, source of injury, network or any other limitation on benefits that would otherwise be covered.
- Not to issue individual health insurance coverage to an applicant, including coverage offered to an individual through a non-employer group.
- To rescind coverage on a health benefit plan.

AFFILIATION/PROBATIONARY/WAITING PERIOD. A period which must expire before the new employee's health care coverage becomes effective. This period will not exceed 90 days. See your benefit office for details.

APPLIED BEHAVIOR ANALYSIS. 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 environment and behavior.

AUTHORIZED PERSON/REPRESENTATIVE. An individual who represents a member in an Internal Appeal or External Review process of an adverse benefit determination who is any of the following:

- A person to whom a member has given expressed, written consent to represent him/her in an internal appeal process or external review process of an adverse benefit determination.
- A person authorized by law to provide substituted consent for a member.
- A family member or treating health care professional, but only when the member is unable to provide consent.

AUTISM SPECTRUM DISORDER. Any pervasive developmental disorder, or autism spectrum disorder as defined by the most recent edition of the diagnostic and statistical manual of mental disorders published by the American psychiatric association available at the time an individual is first evaluated for suspected developmental delay.

BASIC HEALTH CARE SERVICES. The following services when medically necessary and appropriate:

- Physician services including podiatric and chiropractic.
- Urgent care services.
- Inpatient and outpatient hospital services.
- Diagnostic laboratory.
- Out of area services.
- Emergency services.
- Diagnostic and therapeutic radiological services.
- Preventive Care Services.
- Services designed to remediate and/or treat Behavioral health and substance use disorders as identified by the current American Psychiatric Association's Diagnostic and Statistical Manual and/or the American Society for Addiction Medicine;

There are no lifetime or annual dollar limits on Basic Health Care Services.

BEHAVIORAL HEALTH CONDITIONS.

- **Behavioral Health Disorder.** A display of mental or nervous symptoms that cause impairment in the individual's ability to function and experience a satisfactory quality of life.
- **Substance Use Disorder**. A disorder involving problematic use of a drug, alcohol, or another substance, characterized by symptoms such as excessive use of the substance, difficulty limiting its use, craving, impaired social and interpersonal functioning, a need for increased amounts of the substance to achieve the same effects, and withdrawal symptoms upon discontinuance.

BENEFIT YEAR. The 12 month cycle in which a health plan issuer operates. Some benefit years follow the calendar year, beginning in January, whereas others do not.

CERTIFIED BEHAVIOR ANALYST. An individual who is certified by the Behavior Analyst Certification Board or certified by a similar nationally recognized organization.

CHRONIC PAIN. A non-cancer, non-end of life pain lasting more than three months or longer than the duration of normal tissue healing.

CLINICAL THERAPEUTIC INTERVENTION. Therapies supported by empirical evidences, which include, but are not limited to, applied behavioral analysis, that satisfy both of the following:

- Are necessary to develop, maintain, or restore, to the maximum extent practicable, the function of an individual.
- Are provided by or under the supervision of any of the following:
    - An individual licensed to practice psychology.
    - An individual licensed to practice professional counseling, social work, or marriage and family therapy.

COINSURANCE PAYMENT. The percentage amount required, if any, to be paid by a member for the services outlined in the "Schedule of Benefits." Coinsurance payment normally applies after the deductible has been met.

CONGENITAL. Existing and present at birth. It includes certain mental or physical traits, anomalies, malformations, diseases, etc. They may be either hereditary or due to an influence occurring during gestation up to the moment of birth. This does not include conditions that are developmental in nature (not at birth).

COPAYMENT (Copay). The dollar amount required, if any, to be paid by a member for the services outlined in the "Schedule of Benefits." The copayment amount does not apply to the deductible.

COVERED SERVICES/COVERAGE. The medically necessary and appropriate services, supplies or treatment which are performed, prescribed, directed or authorized by a Provider under this health benefit plan.

CREDITABLE COVERAGE. Coverage of an individual under any of the following:

- Group health plan;
- A Veterans Administration plan;
- Health insurance coverage;
- A public health (domestic or foreign);
- Medicaid;
- Medicare;

- Military health program;
- Peace Corps;
- Indian Health Service/tribal program;
- COBRA;
- S-CHIP program;
- A state health benefits risk pool;

Prior coverage does not qualify if there was a break in coverage under a prior health plan that was longer than a 63-day period.

Upon a member's request, The Health Plan will issue a Certificate of Creditable Coverage.

DEDUCTIBLE. The dollar amount you must pay for covered services within each contract year before benefits will be paid by The Health Plan. Exempt from the deductible, and any member cost sharing, are services and prescriptions covered under "Preventive Care Services".

DEPENDENT. Any member of a subscriber's immediate family who meets all applicable eligibility requirements, has been enrolled with The Health Plan, and for whom the fixed periodic prepayment required by the Service Agreement has been received by The Health Plan.

DURABLE MEDICAL EQUIPMENT (DME)/SUPPLIES. Any equipment that can withstand repeated use, and/or its supplies whether disposable or reusable, made to serve a medical purpose and generally considered useless to a person who is not ill or injured.

Examples of DME are as follows:	**Examples of DME supplies** are as follows:
Decubitus equipment;	Oxygen;
Oxygen equipment;	Nebulizer medications;
Hospital bed;	Infusion set;
Insulin pump; and	Tubing; and
Wheelchair.	Urinary catheters.

EMERGENCY MEDICAL CONDITION. A condition manifesting itself by the sudden and unexpected onset of acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Serious jeopardy to the health of the individual (or an unborn child);
- Serious impairment to bodily functions; and
- Serious dysfunction of any bodily organ or part.

EMERGENCY SERVICES. Health care services that must be available, seven days per week, 24 hours per day in order to prevent jeopardy to an enrollee's health status that would occur if such services were not received as soon as possible; and includes, where appropriate, provisions for transportation and indemnity payments or service agreements for out-of-area coverage to include:

- A medical screening examination, as required by Federal law, that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department, to evaluate an emergency medical condition.

- Such further medical examination and treatment that are required by federal law to stabilize an emergency medical condition and are within the capabilities of the staff and facilities available at the hospital, including any trauma and burn center of the hospital.

EMPLOYEES. Includes the officers, managers and employees (to include retirees if applicable), the partners if the employer is a partnership, the officers, managers and employees of subsidiary or affiliated corporations of a corporation employer and the individual proprietors, partners and employees of individuals and firms, the business of which is controlled by the insured employer through stock ownership, contract or otherwise.

EMPLOYERS. Includes any municipal or governmental corporation, unit, agency or department thereof, as well as private individuals, partnerships and corporations.

ENROLLMENT AREA. The geographical area encompassing the following counties:

Ohio:

Ashland	Delaware	Holmes	Lorain	Muskingum	Summit
Athens	Fairfield	Hocking	Mahoning	Noble	Trumbull
Belmont	Franklin	Jackson	Medina	Perry	Tuscarawas
Carroll	Gallia	Jefferson	Meigs	Pickaway	Vinton
Columbiana	Geauga	Knox	Monroe	Portage	Washington
Coshocton	Guernsey	Lawrence	Morgan	Richland	Wayne
Cuyahoga	Harrison	Licking	Morrow	Stark	

The Ohio Department of Insurance may approve additional counties from time to time. Enrollment Area may also include any county that borders the approved counties provided the subscriber residing in the border county is employed within the Service Area.

West Virginia (entire state):

Barbour	Grant	Logan	Nicholas	Summers
Berkeley	Greenbrier	Marion	Ohio	Taylor
Boone	Hampshire	Marshall	Pendleton	Tucker
Braxton	Hancock	Mason	Pleasants	Tyler
Brooke	Hardy	McDowell	Pocahontas	Upshur
Cabell	Harrison	Mercer	Preston	Wayne
Calhoun	Jackson	Mineral	Putnam	Webster
Clay	Jefferson	Mingo	Raleigh	Wetzel
Doddridge	Kanawha	Monongalia	Randolph	Wirt
Fayette	Lewis	Monroe	Ritchie	Wood
Gilmer	Lincoln	Morgan	Roane	Wyoming

EXIGENT. Requiring immediate aid or action.

EXPERIMENTAL AND INVESTIGATIONAL. Any treatment, procedure, facility, equipment, drug, device or supply which The Health Plan does not recognize as accepted medical practice or which does not have required governmental approval. This includes treatments and procedures which:

- Are still in the investigative or research state;
- Have not been adopted for general clinical use;
- Have not been approved or accepted by the appropriate review body; and
- Are not generally accepted by the local medical community as safe, appropriate and effective treatment.

This determination is based on the recommendation of the Medical Advisory Committee, the most recent Hayes Medical Technology Directory®, and on current evidenced-based medical/scientific publications.

FEDERALLY ELIGIBLE INDIVIDUAL. An individual is one for whom, as of the date coverage is sought, the aggregate of the periods of creditable coverage is 18 months and whose coverage ended no more than 63 days before the date of application to The Health Plan. The person's most recent prior creditable coverage must also have been under a group health plan, governmental plan or church plan. This coverage must not have been terminated due to non-payment of premium or fraud. This person must not be eligible for coverage under a group plan, Medicare or Medicaid.

FINAL ADVERSE BENEFIT DETERMINATION. An adverse benefit determination that is upheld at the completion of a health plan issuer's Appeals process.

FIXED PERIODIC PREPAYMENT. The amount established for monthly premium payment in return for covered health care services.

HABILITATIVE SERVICES. Health care services and devices that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

HEALTH BENEFIT PLAN. A policy, contract, certificate, or agreement offered by a health plan issuer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

HEALTH CARE SERVICES. Basic, supplemental, and specialty health care services. Services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

HOSPICE CARE. An agency or organization that mainly provides palliative care to terminally ill patients. Hospice care helps those persons continue their lives with as little disruption as possible. This type of care promotes supportive services such as home care and pain control rather than cure oriented services. Hospice care is limited to members that have a medical prognosis of six months, or less, life expectancy.

HOSPITAL. An institution licensed and operated primarily as a general or special acute care hospital giving inpatient health care services for medical and surgical cases. The institution must be operating according to applicable law and be contracted with or approved by The Health Plan to provide hospital services to members.

The term "hospital" does not include a convalescent nursing home or any institution or part thereof, which is used principally as a convalescent facility, rest facility, nursing facility, or facility for the aged.

HOSPITAL SERVICES. Those services for registered patients which are as follows:

- Services that customarily are provided by an acute care hospital that contracts with The Health

Plan; and

- Services that are prescribed, directed, or authorized by a Network physician and approved by The Health Plan.

IDENTIFICATION CARD/ID CARD. A card issued by The Health Plan. Each member has been assigned a unique ID number that allows physicians and facilities be able to verify your health insurance coverage. The ID card lists member's name, identification number, The Health Plan contact information (website, phone numbers etc.). The names of covered family members (e.g., spouse, children) will also appear on the card.

ILLNESS. A condition for which a member is treated. Illness means any covered disease or bodily or mental infirmity, including normal pregnancy and resulting childbirth.

INDEPENDENT REVIEW ORGANIZATION (IRO). An entity that is accredited to conduct Independent External Reviews of adverse benefit determinations.

INJURY. Accidental bodily damage suffered by a member.

INPATIENT. A member admitted to a hospital as a registered bed patient (room and board charge is made) and is receiving services under the direction of a physician that the member could not receive as safe-adequate care as an outpatient. The does not apply to a member who is placed under observation for fewer than 24 hours.

MAXIMUM ALLOWABLE AMOUNT. The maximum dollar amount The Health Plan will pay for a health care service. This can also be called "eligible expense, payment allowance". If your Network provider bills you for more than The Health Plan's allowed amount, you do NOT have to pay the difference. You are only responsible for your copayment/coinsurance for covered services.

MEDICAID PROGRAMS. State medical assistance programs established by Title XIX of the Social Security Act and all amendments thereto.

MEDICAL SERVICES. Those professional services of physicians and other medical professionals. These include medical, surgical, diagnostic, therapeutic, and preventive services. These services must be performed, prescribed or directed by the primary, secondary or specialty care physician or other health care professionals.

MEDICALLY NECESSARY AND APPROPRIATE. When used to describe services or supplies proposed or received means that The Health Plan or our designee has determined that the service or supply meets its criteria for medical necessity. These criteria are derived from recognized accredited national sources such as national medical specialty societies or widely representative groups of specialists (and sometimes from regional or local members of the medical community or academic faculties) convened for the purpose. They are subject to regular review and revision when appropriate. They are also validated by committees of physicians drawn from The Health Plan's panels of local and tertiary providers.

Services or supplies must be:

1. For the purpose of evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms.
2. In accordance with the standards of good medical practice in the local area.
3. Clinically appropriate, in terms of type, frequency, extent, site, and duration, etc., and considered effective for the patient's illness, injury, disease.
4. Not primarily for the convenience of you or your doctor.

5. 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.

It is important to recognize that even though a physician may have recommended a service or supply it may sometimes not qualify as being medically necessary.

MEDICARE ACT. Title XVII of the Social Security Act and all amendments thereto.

MEMBER. A subscriber, covered person, enrollee, or individual who has satisfied eligibility requirements, applied for coverage, and has been approved by a health benefit plan. "Member" does include the member's authorized representative with regard to an Internal Appeal or External Review. Members are sometimes called "you" or "your" in this health benefit plan.

NETWORK. Network, In-Network or The Health Plan Network, mean the physicians, hospitals or other providers under contract with The Health Plan.

NETWORK PROVIDER. A physician, hospital or other health service provider who has a contract with The Health Plan to provide covered services to members.

OBJECTIVE EVIDENCE. Standardized patient assessment instruments, outcome measurement tools, or measurable assessments of functional outcome.

ORTHOTIC. A device meant to correct any defect in form or function of the body; for example, a brace (non-dental), support, or splint.

OSTEOTOMY. A surgical procedure to cut through a bone.

OUT-OF-NETWORK. Physicians, providers or hospitals not under contract with The Health Plan to furnish health care to members.

OUTPATIENT. Treatment that is received by a member at a hospital under a physician's direction but not on an inpatient hospital basis.

OUTPATIENT HOSPITAL OBSERVATION BED. A level of care that allows a patient to remain in a suitable facility of the hospital for extension of emergent/urgent diagnosis and treatment. No admission to an acute care facility occurs.

PHARMACY. An establishment licensed to dispense Prescription Drugs and other medications through a duly licensed pharmacist upon a physician's order.

PHARMACY CARE. Medications prescribed by a licensed physician and any health-related services considered medically necessary to determine the need or effectiveness of the medications.

PHYSICIAN OFFICE VISIT. May include, but is not limited to specific medical services of physicians and/or assistants (including nurse practitioners and midwives) in an office setting.

PLAN (OR WE, US, OUR). The Health Plan, which provides benefits to members for the covered services described in this certificate.

PLAN PERSONNEL. The personnel employed directly by The Health Plan as an employee to assist in carrying out its obligations under this health benefit plan. They may include, but is not limited to medical director(s), nurses, administrative and clerical staff, and other various positions.

PRE-ADMISSION. Occurring in or relating to the period prior to admission (as to a hospital).

PREAUTHORIZATION. A decision by The Health Plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. The Health Plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise The Health Plan will cover the cost.

PREVENTIVE CARE SERVICES. Those covered services that are provided to a member who has developed risk factors (including age and gender) for a disease for which the member has not yet developed symptoms and immunizations to prevent specific diseases.

PRIOR AUTHORIZATION REQUIREMENT – any practice in which coverage of a health care service, device, or drug is dependent upon a covered person or a health care practitioner obtaining approval from the plan prior to the service, device, or drug being performed, received, or prescribed, as applicable. "Prior Authorization" includes prospective or utilization review procedures conducted prior to providing a health care service, device, or drug.

PROSTHETIC AND PROSTHETIC SUPPLIES. An externally attached or surgically implanted artificial substitute, and/or its supplies whether disposable or reusable, for an absent/non- functioning body part; for example, an artificial limb and supplies such as ostomy bags.

PROVIDERS. Physicians, hospitals and any other facility or person providing health or medical services.

PSYCHIATRIC CARE. Direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

PSYCHOLOGICAL CARE. Direct or consultative services provided by a psychologist licensed in the state in which the psychiatrist practices.

QUALIFIED MEMBER. A member who is enrolled or participating in a health plan or coverage and who is eligible to participate in an approved clinical trial according to the trail protocol with respect to treatment of cancer or another life-threatening disease or condition. A determination is required that the member's participation in the approved clinical trial is appropriate to treat the disease or condition. This determination can be made based on the referring health care provider's conclusion or based on the provision of medical and scientific information by the member. Members seeking participation in a cancer clinical trial do not have to meet the definition of a qualified member.

REHABIITATION SERVICES. Health care services or devices designed to facilitate the process of recovery from injury, illness, or disease to as normal a condition as possible.

RESCISSION or "TO RESCIND". A cancellation or discontinuance of coverage that has a retroactive effect. "Rescission" does not include a cancellation or discontinuance of coverage that has only a prospective effect or a cancellation or discontinuance of coverage that is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

RESIDENTIAL CARE. Care given to adults or children who stay in a residential setting rather than in their own home or family home.

RETROSPECTIVE REVIEW. Review of medical necessity that is conducted by The Health Plan after health care services have been provided to a member. Retrospective review does not include the review of any claims. This review is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication of payment.

SCHEDULE OF BENEFITS. The list of benefits or coverage that entails all medical, hospital, and other services under this health benefit plan.

SERVICE AGREEMENT. "The Health Plan Group Medical and Hospital Service Agreement" between Health Plan and your employer.

SERVICE AREA. The geographical area that The Health Plan serves. It encompasses Ohio and West Virginia counties (see Enrollment Area for listing of counties)

SKILLED NURSING FACILITY. An inpatient facility that provides services to members requiring 24-hour a day skilled nursing care. This care is provided directly by or requires the supervision of registered professional nursing staff. It also may include other skilled rehabilitative services. The facility must also meet Medicare requirements.

SMALL EMPLOYER. In connection with a group health plan and with respect to a calendar year and a plan year, an employer who employed an average of at least one (1) but no more than 50 eligible employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year.

SPECIALIST. A physician specializing in a particular field such as cardiology, urology or dermatology.

STABILIZE. The provision of such medical treatments as may be necessary to assure, within reasonable medical probability that no material deterioration of a member's medical condition is likely to result from or occur during a transfer, if the medical condition could result in any of the following:

- Placing the health of the covered person or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy;
- Serious impairment to bodily functions; and
- Serious dysfunction of any bodily organ or part.

In case of a woman having contractions, "stabilize" means such medical treatment as may be necessary to deliver, including the placenta.

SUBSCRIBER. A person who is responsible for making payments to a health benefit plan for participation in the health benefit plan.

TELEMEDICINE - a mode of providing health care services through synchronous or asynchronous information and communication technology by a health care professional, within the professional's scope of practice, who is located at a site other than the site where the recipient is located.

TERTIARY FACILITY/PROVIDER. A provider that The Health Plan contracts with to provide services to our members when that care is NOT available through the local networks. These Tertiary Providers do require preauthorization in order for services to be covered at an In Network level of care.

THERAPEUTIC CARE. Services provided by a speech therapist, occupational therapist, or physical therapist licensed or certified in the state in which the person practices.

TREATMENT FOR AUTISM SPECTRUM DISORDER. Evidence-based care and related equipment prescribed or ordered for an individual diagnosed with an autism spectrum disorder by a licensed physician who is a developmental pediatrician or a licensed psychologist trained in autism who determines the care to be medically necessary and appropriate.

URGENT CARE SERVICES. Those health care services that are appropriately provided for an unforeseen condition of a kind that usually requires medical attention without delay but that does not pose a threat to the life, limb, or permanent health of the injured or ill person.

USUAL, CUSTOMARY AND REASONABLE (UCR) CHARGES. The charges that Health Plan determines do not exceed the amount usually charged by most providers in the same geographic area for services, treatment or material, taking into account the nature of the illness or injury.

UTILIZATION REVIEW. A process used to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, services, procedures, or settings. Areas of review may include ambulatory review, second opinion, certification, concurrent review, case management, discharge planning, or Retrospective Review.

21. POS SCHEDULE OF BENEFITS.

Each member has the responsibility to understand how the Plan benefits are administered. This responsibility includes how, when and the accumulation of deductibles and out-of-pocket maximums.

Contract Year Maximum Benefits		
Type of Expenses	**Network**	**Out-of-Network**
DEDUCTIBLE		
Individual	**$1,200**	**$2,400**
Family	**$2,400**	**$4,800**
Benefits are subject to a contract year deductible that must be paid by the member before benefits are payable by The Health Plan. Exempt from the deductible, and any member cost sharing, are services and prescriptions covered under In-Network Preventive Care Services. Only expenses that you and your eligible dependents incur for covered services count toward satisfying your annual deductible. The chart above lists your deductible amounts under this Certificate. Network and Out-of-Network deductibles are not accumulative. To help employees with several covered dependents, the deductible you pay for the entire family, regardless of family size, is specified as a family deductible maximum. To meet the family deductible maximum, you can count the eligible expenses incurred by two or more family members. The deductible amounts contributed by any one family member shall not exceed that of an individual annual deductible maximum amount. Any amounts by which an Out-of-Network provider's billed charges exceed the UCR payment level used by The Health Plan to reimburse Out-of-Network providers will not be counted toward satisfying your Out-of-Network deductible. Deductible amounts accumulate toward the annual out-of-pocket maximum amounts (see below).		
OUT-OF-POCKET MAXIMUM		
Individual	**$6,850**	**$10,000**
Family	**$13,700**	**$20,000**
Once the In-Network annual out-of-pocket maximum is satisfied, The Health Plan waives any additional In-Network copayments or coinsurance payments for the remainder of the benefit year. In-Network and Out-of-Network out-of-pocket amounts are not accumulative. Please refer to the annual out-of-pocket maximum listed above. Expenses you incur for satisfying your annual deductible do accumulate toward your annual out-of-pocket maximum. The In-Network copayment, coinsurance payment, and deductible amounts contributed by any one family member shall not exceed that of an In-Network individual annual out-of-pocket maximum amount.		

SERVICES REQUIRING PREAUTHORIZATION/REFERRAL

Most Network providers know which services require preauthorization and they have been provided with detailed information on the process.

Please see "Health Care / Utilization Management" on how to obtain a preauthorization/referral.

If you, or your physician, have a question regarding preauthorization, please contact a Health Plan Customer Service Representative at: 888.847.7902; TDD 711 or email: info@healthplan.org.

HELP US HELP YOU!

Help stop insurance fraud. Each incident uncovered and stopped saves you and every other member money. That is as important to us as it is to you. Health care fraud usually takes the form of false or misleading claims for payment submitted to insurance carriers and health care plans. Local and toll-free "FRAUD" hotline phone numbers are now available. If at any time you may have concerns or questions about charges or payments made for you or an eligible dependent, feel free to call The Health Plan's Fraud Hotline at 877.296.7283.

COVERED SERVICES

Deductible will apply unless otherwise noted.

Limits and maximums are per member per contract year unless specifically stated otherwise.

Visit limits are combined for In-Network and Out-of-Network.

Hospital/Medical Expenses	Network	Out-of-Network
Physician Services		
Office Visits		
Primary Care Physician (PCP)	$10 copayment (deductible waived)	40% coinsurance after deductible
Specialist (SCP)	$40 copayment (deductible waived)	40% coinsurance after deductible
Telemedicine Services	Copayment or coinsurance payment is based on the type of service received.	Copayment or coinsurance payment is based on the type of service received.
Other Practitioner Office Visit	Copayment or coinsurance payment is based on the type of service received.	Copayment or coinsurance payment is based on the type of service received.
Physician Home Visit	Copayment or coinsurance payment is based on the type of service received.	Copayment or coinsurance payment is based on the type of service received.
Allergy Services		
Injections & Serums	$0 copayment after deductible	40% coinsurance after deductible
Testing	$0 copayment after deductible	40% coinsurance after deductible
Note(s): The allergy injection copay or coinsurance payment will be applied when the injection(s) is billed by itself. The office visit copay or coinsurance payment will apply if an office visit is billed with an allergy injection. Drugs obtained under the prescription benefit will have separate copayment or coinsurance payment.		
Autism Spectrum Disorder		
Services for the diagnosis and treatment of Autism Spectrum Disorder. **Note:** Covered Services will be paid according to the benefit category (e.g. Occupational Therapy, Office Visit, etc.)	Copayment/Deductible/Coinsurance determined by service received.	Copayment/Deductible/Coinsurance determined by service received.
For Behavioral Health Outpatient Services see "Behavioral Health Outpatient Services".		

Hospital/Medical Expenses	Network	Out-of-Network
Behavioral Health Outpatient Services		
Behavioral Health Disorders	$10 copayment deductible waived	40% coinsurance after deductible
Substance Use Disorders	$10 copayment deductible waived	40% coinsurance after deductible
Note: Services provided may be no more restrictive than medical-surgical services.		
Behavioral Health Inpatient Services		
Behavioral Health Disorders	$100 copayment + 30% coinsurance after deductible	50% coinsurance after deductible
Substance Use Disorders	$100 copayment + 30% coinsurance after deductible	50% coinsurance after deductible
Note: Services provided may be no more restrictive than medical-surgical services. For Physician services see "Inpatient Physician and Surgical Services".		
Dental Services (only when related to accidental injury)	$100 copayment + 30% coinsurance after deductible	50% coinsurance after deductible
Limit(s): Services resulting from an accidental injury when treatment is performed within 12 months, or as soon as reasonably possible after injury. Limited to $3,000 per accident. **Note(s):** Benefit limit will not apply to: outpatient facility charges, anesthesia billed by a provider other than the physician performing the service or to services that The Health Plan is required to cover by law.		
Non-Routine Dental Services for Specified Conditions	30% coinsurance after deductible	50% coinsurance after deductible
Note(s): Limited to facility charges for Outpatient Services for the removal of teeth or for other dental processes only if the member's medical condition or the dental procedure requires a hospital setting to ensure the safety of the member.		
Diabetic Equipment, Education, and Supplies (for all diabetics)		
Insulin Pumps/Pump Supplies (see "DME" benefit)	30% coinsurance after deductible	50% coinsurance after deductible
Education	No charge	40% coinsurance after deductible
Supplies	No charge	40% coinsurance after deductible
Note(s): Covered supplies at no cost to you are limited to: glucometers, syringes, lancets, glucose test strips, alcohol swabs, carp-u-jet, urine ketone testing strips, and penlets. Continuous Glucose Monitoring Supplies and Devices are not included under "No Charge" offering. Other covered supplies see "Medical Supplies, Durable Medical Equipment (DME), and Appliances". Certain supplies will be provided through the prescription benefit. The Health Plan may require the use of specific brands of glucometers and test strips to ensure consistency of training and education.		

Hospital/Medical Expenses	Network	Out-of-Network
Diagnostic Services		
Advanced Radiology (to include MRI, CAT & PET scans)	30% coinsurance after deductible	50% coinsurance after deductible
Radiology	30% coinsurance after deductible	50% coinsurance after deductible
Laboratory	30% coinsurance after deductible	50% coinsurance after deductible
Note: Laboratory services received at a preferred lab may not be subject to deductible or coinsurance if lab work is sent to LabCorp.		
Durable Medical Equipment (DME), Medical Supplies and Appliances	50% coinsurance after deductible	50% coinsurance after deductible
Note(s): If DME or appliances are obtained through an office setting, urgent care center, Outpatient Services, or Home Care Services the copay or coinsurance payment listed above will apply in addition to the copay or coinsurance payment in the setting where covered services are received.		
Emergency Services		
Accident & Illness	$250 copayment deductible waived	$250 copayment deductible waived
Ambulance/Emergency Transportation	$75 copayment after deductible	$75 copayment after deductible
Non-Emergent Services	Not covered	Not covered
Note(s): Copay or coinsurance is waived only if admitted to inpatient status. Observation days/hours will still require an ER copay or coinsurance in addition to outpatient copay or coinsurance. Covered services are paid at the Network level for true emergencies. However, Non-Network providers may also bill you for any charges that exceed the Usual, Customary and Reasonable (UCR) charges.		
Home Health Care	$0 copayment after deductible	40% coinsurance after deductible
Limit: 100 visits per contract year combined for In-Network and Out-of-Network.		
Note(s): Maximum does not include Home Infusion Therapy or Private Duty Nursing rendered in the home.		
Hospice Services	$0 copayment after deductible	40% coinsurance after deductible

Hospital/Medical Expenses	Network	Out-of-Network
Human Organ and Tissue Transplant Services		
Inpatient hospital and physician services	$100 copayment + 30% coinsurance after deductible	50% coinsurance after deductible
Transportation and Lodging	$10,000 maximum	
Unrelated Donor Searches	$30,000 maximum	
Live Donor Health Services	Copay or coinsurance payment is based on setting where services are received	Copay or coinsurance payment is based on setting where services are received
Note(s): Medically necessary charges for the procurement of an organ from a live donor are covered up to the maximum allowable amount, including complications from the donor procedure for up to six weeks from the date of procurement.		
Infertility Services Note(s): Limited to health care services (diagnostic and exploratory procedures to determine infertility including surgical procedures) to correct diagnosed diseases of conditions.	30% coinsurance after deductible	40% coinsurance after deductible
Injectable drugs and other drugs administered in a providers office or other outpatient setting **Note(s):** Drugs obtained under the prescription benefit will have separate copay or coinsurance payment.	Copayment or coinsurance payment is based on the setting where services are received.	Copayment or coinsurance payment is based on the setting where services are received.
Inpatient Hospital Services (e.g., hospital stay)	$100 copayment + 30% coinsurance after deductible	50% coinsurance after deductible
Inpatient Physician and Surgical Services **Limit:** One visit per day/per any one physician	30% coinsurance after deductible	50% coinsurance after deductible
Maternity Services (delivery)	$100 copayment + 30% coinsurance after deductible	50% coinsurance after deductible
Orthotics & Supplies	30% coinsurance after deductible	50% coinsurance after deductible

Hospital/Medical Expenses	Network	Out-of-Network
Outpatient Physician Services	30% coinsurance after deductible	50% coinsurance after deductible
Outpatient Services	30% coinsurance after deductible	50% coinsurance after deductible
Outpatient Surgery/Surgical Services	$100 copayment + 30% coinsurance after deductible	50% coinsurance after deductible
Preventive Care (as defined by ACA)		
Family Planning	No charge	Not Covered
Screening Colonoscopies	No charge	40% coinsurance after deductible
Screening Mammograms	No charge	40% coinsurance after deductible
Screening Pap Smears	No charge	40% coinsurance after deductible
Well Adult Care	No charge	40% coinsurance after deductible
Well Child Care	No charge	40% coinsurance after deductible
Note(s) : More covered preventive care services see: healthcare.gov/coverage/preventive-care-benefits		
Physical Rehabilitation Facilities **Limit:** 60 days per contract year combined for In-Network and Out-of-Network.	Days 1-30, $0 copayment after deductible; Days 31+, 30% coinsurance after deductible	50% coinsurance after deductible
Note(s): Includes coverage for Day Rehabilitation. Program services subject to combined 60 day limit with inpatient services combined for In-Network and Out-of-Network.		
Private Duty Nursing Outpatient only	20% coinsurance after deductible	40% coinsurance after deductible
Limit: 100 visits per contract year combined for In-Network and Out-of-Network.		
Prosthetics & Supplies	30% coinsurance after deductible	50% coinsurance after deductible
Reconstructive/Cosmetic Surgery	Copayment or coinsurance payment is based on the setting where services are received.	Copayment or coinsurance payment is based on the setting where services are received.

Hospital/Medical Expenses	Network	Out-of-Network
Skilled Nursing Facility **Limit:** 90 days per contract year combined for In-Network and Out-of-Network	$35 copayment after deductible	40% coinsurance after deductible
Temporomandibular Joint Disorder or Craniomandibular Joint/Jaw Disorder (TMJ/CMD)	40% coinsurance after deductible	50% coinsurance after deductible
Therapy, Rehabilitative and Habilitative, Services – If different types of Therapy Services are performed during one Physician Home Visit, Office Service, or Outpatient Service then each different type of Therapy Service performed will be considered a separate Therapy visit. Visits are Rehabilitative and Habilitative combined. All visit limits are combined for In-Network and Out-of-Network.		
Note: *Chronic Pain benefits limited to 20 visits per event for combined physical therapy, occupational therapy, and spinal manipulations with a PCP cost-sharing per visit.*		
Occupational Therapy (Rehabilitative and Habilitative)	Visits 1-20, $40 copayment after deductible; visits 21+ 50% coinsurance after deductible	40% coinsurance after deductible; visits 21+, 50% coinsurance after deductible
Physical Therapy (Rehabilitative and Habilitative)	Visits 1-20, $40 copayment after deductible; visits 21+ 50% coinsurance after deductible	40% coinsurance after deductible; visits 21+, 50% coinsurance after deductible
Speech Therapy (Rehabilitative and Habilitative)	Visits 1-20, $40 copayment after deductible; visits 21+ 50% coinsurance after deductible	40% coinsurance after deductible; visits 21+, 50% coinsurance after deductible
Spinal Manipulations (to include Chiropractic Care) **Limit:** 20 combined rehabilitative/habilitative visits per contract year.	$40 copayment (deductible waived)	40% coinsurance after deductible
Cardiac Rehabilitation **Limit:** 36 visits per contract year.	$10 copayment after deductible	40% coinsurance after deductible

Hospital/Medical Expenses	Network	Out-of-Network
Pulmonary Rehabilitation	$10 copayment after deductible	40% coinsurance after deductible
Limit: 36 visits per contract year. When rendered as part of physical therapy, the physical therapy limit will apply instead of the limit listed here.		
Chemotherapy Note: Administered in an outpatient setting.	20% coinsurance after deductible	40% coinsurance after deductible
Radiation Therapy Note: Administered in an outpatient setting.	20% coinsurance after deductible	40% coinsurance after deductible
Urgent Care Facility	$50 copayment (deductible waived)	$50 copayment (deductible waived)
Note(s): Allergy testing, MRA, MRI, PET scan, CAT scan, nuclear cardiology imaging studies, non-maternity related ultrasound services, pharmaceutical injection(s), and drugs received in an urgent care center may be subject to the Outpatient Services copay or coinsurance payment.		
Vision correction after surgery or accident	20% coinsurance after deductible	40% coinsurance after deductible

PRESCRIPTION DRUG BENEFITS

Prescription Drug Benefits	Network	Out-of-Network
Preferred Generic Drugs ***** Insulin Policy** **Note(s):** Preventive care prescriptions are covered at no cost to the member.	$10 copayment /each/retail/31-day supply (deductible waived) $20 copayment/each/home delivery/90-day supply (mail order) (deductible waived)	Not covered
Preferred Brand Drugs **See: *Generic Difference Policy and *** Insulin Policy**	Not Covered	Not covered
Non-Preferred Brand Drugs **See**: ***Generic Difference Policy, **Orally administered cancer drugs, and *** Insulin Policy**	Not Covered	Not covered
Preferred Specialty Drugs **See**: ***Generic Difference Policy and **Orally administered cancer drugs**	$300 copayment or 30% coinsurance payment whichever is less each/retail/home delivery31 day supply (mail order) **Generic Only** (deductible waived)	Not covered
***Generic Difference Policy**. If the prescriber specifies that a qualified formulary or non-formulary brand-name drug must be dispensed when the generic equivalent is available (DAW-1), or the prescription order allows for the generic substitution and the member elects to have the prescription filled with a qualified formulary or non-formulary brand-name drug instead (DAW-2), the member must pay the qualified formulary or non-formulary brand copay or coinsurance payment plus the cost difference between the Plan's cost of a qualified formulary or non-formulary brand name and its generic equivalent.		
****Orally administered cancer drugs** The Health Plan shall not impose cost sharing for a prescribed, orally administered cancer medication on a less favorable basis than the coverage it provides or cost sharing it imposes for intravenously administered or injected cancer medications. Preauthorization is required.		
*****Cost sharing for prescription insulin drugs** shall not exceed $100 for a 30-day supply of a covered prescription insulin, regardless of the quantity or type of prescription insulin prescribed. Insulin may be restricted to a formulary and require coverage criteria be satisfied.		

22. NON-COVERED SERVICES/ITEMS/EXCLUSIONS.

The following section indicates items or services which are excluded from coverage. This information is provided as a guide to identify certain common items or services which may be mistaken as covered services. This is a guide and is no way a limitation upon, or complete listing of, items or services considered not to be covered. We have final authority for determining if services or supplies are medically necessary and appropriate and covered services. The Health Plan's final authority is subject to any appeal process.

Non-covered services include, but are not limited to the following:

1. Hospital and medical services, or items that are not medically necessary and/or appropriate as determined by The Health Plan. Non-medical treatment, special education and training for dyslexia and global developmental delay.
2. Dental treatment, regardless of origin or cause, except as specified elsewhere in this agreement. Dental treatment includes preventive care, diagnosis, and treatment of or related to the teeth, jawbones (except medically related TMD/CMD) or gums. Extraction, restoration, and replacement of teeth. Medical or surgical treatments of dental conditions. Services to improve dental clinical outcomes. Dental implants and Orthodontic Treatment including braces. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly. Dental x- rays, supplies and appliances and all associated expenses, including hospitalization and anesthesia, except as required by law or specifically stated as a covered service. The only exceptions are:
    - Transplant preparation
    - Initiation of immunosuppressives
    - Direct treatment of acute traumatic injury, cancer, or cleft palate
3. Treatment or services for:
    - Custodial care, convalescent care or rest cures
    - Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, supervised living or halfway house, or any similar facility or institution
    - Services or care provided or billed by a school, custodial care center for the developmentally disabled
    - Wilderness camps
4. Items or medical and hospital services deemed to be investigational or experimental by The Health Plan in conjunction with its specialty consultants, appropriate governmental agencies and other regulatory agencies as interpreted by The Health Plan. If medically acceptable and conventional techniques or treatment are available, new ones may <u>not</u> be covered. At such time as these new procedures, techniques, or treatments become non-experimental or investigational and are medically necessary and appropriate, then they may be covered. The fact that a service is the only available treatment for a condition will not make it eligible for coverage if we deem it to be experimental or investigational.
5. If otherwise standard treatment items such as human tissues, anatomic structures, and blood or blood derivatives are prohibited in the treatment of an individual based only by non-medical considerations (e.g., relating to religious restrictions or personal preferences) the alternative products used as substitutes are not a covered benefit.
6. Private rooms except when medically appropriate and authorized by The Health Plan. Personal or

comfort items and services (e.g., guest meals and lodging, radio, television, and phone) unless specifically stated otherwise in this agreement.

7. Benefits provided by any governmental unit unless otherwise required by law or regulation.
8. Any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Workers' Compensation Act or other similar law. If Workers' Compensation Act benefits are not available to you, then this exclusion does not apply. This exclusion applies if you receive the benefits in whole or part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.
9. Reversal of voluntary sterilization and associated services and/or expenses.
10. Services and supplies related to sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This exclusion includes sexual therapy and counseling, penile prostheses or implants and vascular or artificial reconstruction, prescription drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related diagnostic testing.
11. Services not provided, arranged, or authorized by your physician, except in an emergency or when allowed in this agreement.
12. Elective pre-surgery testing on an inpatient basis without the authorization of The Health Plan's Medical Director.
13. Physical, psychiatric, or psychological exams, testing, or treatments when such services are as follows:
    - Related to employment or school.
    - To obtain or maintain insurance.
    - Needed for marriage or adoption proceedings.
    - Related to judicial or administrative proceedings or orders.
    - Conducted for purposes of medical research.
    - To obtain or maintain a license or official document of any type.
    - To participate in sports.

    Exceptions are exams, testing, or treatments that are covered under "Preventive Care Services."
14. Services such as: in-vitro fertilization and gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), embryo transport, donor semen, sperm washing, artificial insemination, drugs (oral, topical or injectable), and experimental services are not covered.
15. Maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.
16. Acupressure, electrolysis, Christian Science treatment, and autopsy. Lamaze classes, paternity testing, and vision therapy.
17. Liposuction, panniculectomies, abdominoplasty (e.g., surgical removal of fatty tissue).
18. Work hardening programs including functional capacity evaluations.
19. Marriage counseling.

20. Weight loss services and associated expenses (e.g., wiring of the jaw, weight control programs, weight control drugs or products and nutritional products or supplements) whether or not they are pursued under medical or physician supervision. Exceptions are obesity counseling and interventions covered under "Preventive Care Services."
21. Safety devices. Devices used specifically for safety or to affect performance including sports-related activities.
22. Hepatitis B vaccine coverage limited to "direct exposure" defined as transmission that occurs through inadvertent percutaneous inoculation, mucosal absorption, or sexual contact with a source currently infected with acute Hepatitis B virus. Vaccines when related to occupation or occupational, professional, and educational requirements and dependent immunizations beyond their 21st birthday. Injections and immunizations required for travel outside the U.S. and associated with natural disasters (including Hepatitis A).
23. Non-medical ancillary services and long-term rehabilitation services for the treatment of chemical dependency.
24. Court ordered services and/or supplies or those required as a condition of parole, probation, release or because of any legal proceeding.
25. Other limitations that are specifically stated in the "Schedule of Benefits" of this document.
26. Most over the counter medications including, but not limited to, laxatives, antacids, and vaginal yeast products. Exceptions are over the counter medications covered under "Preventive Care Services."
27. Any services for which the member has no legal obligation to pay in the absence of this or similar coverage.
28. Services received from, rendered, or prescribed by a provider with the same legal residence as a covered person or who is a member of the covered person's family. This includes spouse, brothers, sisters, parents, or children. Services received or rendered by a provider to themselves.
29. Services rendered outside the scope of a provider's license.
30. Any illness or injury that occurs while serving in the armed forces, including as a result of any act of war, declared or undeclared.
31. Services or supplies primarily for educational, vocational, training purposes or cognitive in nature except as otherwise specified herein.
32. Non-medical services related to the treatment of Temporomandibular Joint Dysfunction (TMD), Craniomandibular Joint Dysfunction (CMD), and stylomandibular ligament including; but not limited to, braces, non-invasive conditions, experimental procedures, splints, or other appliances.
33. Services that in the judgment of your physician are not medically appropriate or not required by accepted standards of medical practice or Health Plan rules governing services.
34. Hearing exams unless there is a medical condition that requires such an exam. Exceptions are exams covered under "Preventive Care Services."
35. Hearing aids, exams and fittings except for bone anchored or Cochlear implants.
36. Nutritional and/or dietary supplements, except as covered in this agreement or required under "Preventive Care Services" or other law. This includes, but is not limited to, those nutritional formulas and dietary supplements than can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed Pharmacist.
37. Services performed after your physician has advised that further services are not medically appropriate or not covered services.

38. Non-emergency care when traveling outside the U.S.
39. Services related to Cloning. Other types of artificial or surgical means of conception including drugs administered in connection with these procedures, diagnostic testing, or treatment. Services or supplies to a person not covered under this agreement in connection with surrogate pregnancy including the bearing of a child by another woman for an infertile couple.
40. Long-term/custodial nursing home care.
41. Routine foot care. Cutting or removal or corns and calluses. Nail trimming, cutting or debriding. Hygienic and preventive maintenance foot care including cleaning and soaking the feet, applying skin cream in order to maintain skin tone. Other services that are performed when there is not a localized illness, injury, or symptom involving the foot, cosmetic foot care.
42. Acupuncture. Services or supplies related to alternative or complementary medicine. Examples of services in this category include: acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reiki therapy, herbal, vitamin (not to include prenatal vitamins) or dietary products or therapies. Naturopathy, thermograph, orthomolecular therapy, contact reflux analysis, bioenergial synchronization technique (BEST), iridology study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervations therapy, electromagnetic therapy, and neurofeedback.
43. Equipment, supplies or devices and personal hygiene, environmental control or convenience items of the following types;
    - Humidifiers, air purifiers.
    - Charges for non-medical self-care except as otherwise stated.
    - Purchase or rental of supplies for common household use, such as water purifiers.
    - Allergenic pillows, cervical neck pillows, mattresses, or waterbeds.
    - Exercise equipment (e.g., treadmills and exercycles).
    - Hydraulic van or car lifts, lift chairs, stair lifts.
    - Nutritional products or supplements, dietary supplements and enterals except as provided in this agreement.
    - Professional medical equipment (e.g., blood pressure kits or stethoscopes).
    - Q-tips/swabs, diapers, gauze.
44. Benefits payable under Medicare Parts A, B, and/or D or would have been payable if a member had applied for Parts A, B, and/or D. For the purpose of the calculation of benefits, if the member has not enrolled in Medicare Part B, we will calculate benefits as if they had enrolled.
45. For a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.
46. Charges for:
    - Physician or other providers' charges for consulting with members by phone, fax, electronic mails systems or other consultation or medical management service not involving direct (face-to- face) care with the member except as otherwise stated in this evidence of coverage.
    - Surcharges for furnishing and/or receiving medical records and reports.
    - Charges for doing research with providers not directly responsible for your care.
    - Charges that are not documented in provider records.

- Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending physician.
- Membership, administrative, or access fees charged by physicians or other providers. Examples of administration fees are fees charged for educational brochures or calling a patient to provide their test results.

47. Services received from a dental or medical department maintained by or on behalf of an employer, labor union, trust or similar person or group.
48. Missed or cancelled appointments.
49. Completions of claim forms or charges for medical records or reports unless otherwise required by law.
50. Services incurred prior to your effective date.
51. Services incurred after the termination date of this coverage.
52. Procedures, services, equipment, or supplies provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change, or improve your appearance or are furnished for psychiatric or psychological reasons. No benefits are available for surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts). Complications directly related to non-covered cosmetic services, treatment, or surgery. "Directly related" means that the treatment or surgery occurred as a result of the non-covered cosmetic services, treatment, or surgery. This exclusion does not apply to conditions including but not limited to: myocardial infarction, pulmonary embolism, thrombophlebitis, and exacerbation of co-morbid conditions.
53. Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet, tarsalgia; metatarsalgia; hyperkeratosis.
54. Health club memberships, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a physician. The exclusion also applied to health spas.
55. Phone consultations or consultations via electronic mail or internet/website, except as required by law, authorized by The Health Plan, or as otherwise described in this agreement.
56. Care received in an emergency room which is not emergency care. Suture removal in an emergency room.
57. Eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis or excimer laser refractive keratectomy, unless otherwise specified in this agreement.
58. Self-help training and other forms of non-medical self-care, except as otherwise specified in this agreement.
59. Treatment of telangiectatic dermal veins (spider veins) by any method.
60. Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.
61. Reconstructive services except as specifically stated in the "Covered Services/Items" section of this agreement or as required by law.

62. Surgical treatment of gynecomastia.
63. Transsexual Surgery or any Treatment leading to or in connection with transsexual Surgery.
64. Treatment of hyperhidrosis (excessive sweating).
65. Human growth hormone for children born small for gestational age. It is only a covered service in other situations when allowed by The Health Plan through prior authorization.
66. For devices, products, or supplies with over the counter equivalents and any devices, products, or supplies that are therapeutically comparable to an over the counter drug, device, product, or supply. Exceptions are over the counter devices, products, or supplies covered under "Preventive Care Services."
67. Examinations relating to research screenings.
68. Stand-by charges of a physician.
69. Private Duty Nursing services rendered in a hospital or Skilled Nursing Facility. Private Duty Nursing services are covered only when provided through the home care services benefit as specifically stated in the "Covered Services/Items" section.
70. Maternity services for a covered member who is pregnant for the purpose of serving as a Surrogate Parent.
71. Services or supplies in excess of any maximum limits or benefits.
72. Services excluded elsewhere in this agreement.
73. Defective Services or Supplies.
74. Non-therapeutic abortions.
75. Not Medically Necessary and Appropriate
76. Services outside generally accepted medical standards and practices.
77. Inter-facility air or ground transport that is not deemed medically necessary and appropriate by The Health Plan.
78. Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes, unless covered under "Preventive Care Services."
79. Services that The Health Plan determines are not medically necessary or do not meet The Health Plan medical policy, clinical coverage guidelines, or benefit policy guidelines.